



DriveTime Benefits email: benefits@drivetime.com fx: 888-505-7130
www.drivetimebenefits.com

Step I: Biometric Testing Form

Dear Employee,

Please complete the line below and take this form to your Healthcare Provider.

Employee/Spouse Name

Employee ID #

Dear Provider,

Your patient is a participant in the DriveTime Employee Wellness Program. Our employees receive a substantial medical premium discount for meeting certain biometric levels. In order to remain compliant they and their spouse if covered must complete biometric testing annually, consisting of **glucose** and **cholesterol**.

Please verify that the following participant has completed or has an order for the biometric blood testing by completing the section below. **Please provide a copy of the test results to your patient so he/she may complete an online Health Risk Assessment (HRA) also in compliance with our Wellness Program.**

Check box to indicate the patient has completed the Biometric Blood Test consisting of cholesterol and glucose:		<input type="checkbox"/>
_____ Patient Name		
_____ Provider Name		_____ NPI #
_____ Phone		_____ Date

PLEASE FAX COMPLETED FORM TO 888-505-7130. If you have any questions about the requirements of the program, please feel free to contact the DriveTime Benefits Department.

Thank you for your assistance,

DriveTime Benefits Team
email: benefits@drivetime.com



LifeTime
DriveTime Benefits Package