

Complete this form using results from your most recent health care provider visit to earn credit for the 2022 Well Wisconsin Program. **The form must be submitted by October 14, 2022.** For the Health Check, you may choose to complete an on-site biometric screening, self-collection materials, coaching session, or dental cleaning instead of submitting this form. Log onto [webmdhealth.com/wellwisconsin](http://webmdhealth.com/wellwisconsin) to learn more.

**Step 1:** Enter your name and date of birth.

**Step 2:** Enter the screening values from your most recent health care provider visit.

**Step 3:** Review the consent language, sign, and date.

**Required values include**

- Height
- Weight
- Blood Pressure

*Additional values:*

Depending on your age and risk factors, you may be eligible to receive glucose and cholesterol screenings as a no cost preventive service. Before having these labs completed, check with your health care provider and health insurer.

**Out of pocket costs:**

**Be aware that you will be responsible for copayments, deductibles and/or coinsurance if screening tests are not done for preventive reasons, or if other health issues are discussed during your visit.**

**Step 4: Submit the form by 10/14/2022**

- Securely upload it electronically at:  
<https://www.totalwellnesshealth.com/gravity-landing/wellwi/>
- Fax at: 402-218-4378
- Mail it to: TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127

## Questions?

Contact WebMD Customer Support at 1-800-821-6591 or [CustomerSupport@webmd.net](mailto:CustomerSupport@webmd.net)

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Health Care Provider Form – Well Wisconsin Program

Instructions:

Complete Steps 1-4 on this form to verify that you are current on your preventive healthcare. Submit this form by **October 14, 2022**. Print clearly.

Step 1: Please note this information must match your health insurance enrollment data

First Name: [grid] Last Name: [grid]

Date of Birth: (mm/dd/yyyy) [grid]

Email: (Required to provide confirmation of form receipt.) [grid]

Have you fasted for at least 9 hours? (No food. Only water permitted.) [radio] Yes [radio] No
Are you pregnant? [radio] Yes [radio] No

Step 2: Complete

Date of Screening: (mm/dd/yyyy) [grid]
REQUIRED Blood Pressure: [grid] / [grid]
REQUIRED Height: [grid] [grid]
REQUIRED Weight: [grid] [grid]
Waist: [grid] [grid]
Glucose: [grid] Total Cholesterol: [grid] HDL: [grid] LDL: [grid] Triglycerides: [grid]

Health Care Provider Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Health Care Clinic: \_\_\_\_\_

Step 3: Complete

Disclosure of Information. I understand that the information submitted on this form (my "Personal Information") will be transferred to WebMD by TotalWellness. My Personal Information is used by WebMD to provide wellness program services to me, which includes using the Personal Information to inform me of relevant health related and health education programs offered by WebMD or by another service contractor. In the event that WebMD's services are transitioned to another service provider, WebMD may deliver my Personal Information to the successor provider to maintain a continuity of services for me. In order to distribute any incentives, WebMD may provide my name/unique ID to my employer or its designated representative to notify them of the fact that I am eligible for the incentive. In addition to any Personal Information disclosed as set forth above, aggregate, de-identified survey results may be made available to my employer for program administration purposes. WebMD may also use my Personal Information as part of group statistical research and analysis, in a manner that does not identify me. I also understand that my Personal Information may be incorporated into my Health Assessment results by WebMD. Except for these types of usage and the uses specified in my WebMD Online terms of use and Privacy Policy, available under the "Policies" link at the bottom of the following URL (webmdhealth.com/wellwisconsin), my Personal Information will not be disclosed by WebMD. WebMD understands that Personal Information may be considered protected health information that is subject to the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). WebMD will comply with the HIPAA to the extent applicable.

GINA Notice and Authorization. This screening is part of your employer's wellness program ("Employer Program"), which is a voluntary wellness program administered according to federal rules, including the Genetic Information Nondiscrimination Act ("GINA"). The results of this screening may be considered information protected under GINA ("GINA Protected Information"). GINA requires that you receive this GINA Notice and Authorization prior to undergoing the screening. Your Employer Program uses GINA Protected Information to help you understand your potential health risks and to offer you other wellness program services. The Employer Program safeguards GINA protected information and will not disclose any GINA Protected Information, except as permitted by GINA and other applicable law. Your GINA Protected Information will be disclosed to you and to vendors of the Employer Program, for purposes of providing you with Employer Program services. Your GINA Protected Information will not be sold, exchanged or transferred, except to the extent permitted by law to carry out activities related to the Employer Program. You will not be asked to waive the confidentiality of this information as a condition of participating in the Employer Program or as a condition of receiving any incentive. Your GINA Protected Information will only be disclosed to your employer in aggregate terms that do not disclose your specific identity. You may not be discriminated against in employment because of the GINA Protected Information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

Certification: By signing this form, I certify that the information supplied on this form is accurate and has been provided by me by my physician.

X \_\_\_\_\_
Participant Signature Authorizing Disclosure (REQUIRED) Date

Step 4: Submit Form by 10/14/2022 Participant may fax this form to 402-218-4378, mail it to TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127 or securely upload it electronically at totalwellnesshealth.com/gravity-landing/wellwi/. If you entered your email address, you will receive verification that your form has been received within two business days.