WebMD health services

THRIVE Wellness Program 2024 Health Care Provider Form

Instructions:

1. Participation in this program is entirely voluntary. If you choose to participate, please complete all participant information, including email, and sign the form.
2. Visit your health care provider for a biometric screening and take this form.
3. Ask your provider to complete the Biometric Screening Information section using results obtained between 12/1/2023 and 11/30/2024 and sign the form.
4. Submit form once, using one method listed below. **Forms must be RECEIVED by 11/30/2024**. Forms received after the deadline will not be accepted.
   a. Securely upload online at **https://totalwellnesshealth.com/gravity-landing/post/** (**preferred method);**
   b. Fax to 402-939-0604; or
   c. Mail to TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127. **Forms must be received by 11/30/2024.** Please allow sufficient time for mailing.
5. Within 48 hours of form receipt, a confirmation email will be sent to the email listed below. If a confirmation email is not received within 48 hours, please resubmit your form.
6. Please allow 10 business days for the information to be available on the portal.

PARTICIPANT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: (mm/dd/yyyy) __ __ / __ __ / __ __ __ __ Employee ID: (Do not include leading zeros) _____

Email: (Required to provide confirmation of form receipt.) _____

Gender: ○ Male ○ Female

Have you fasted (no food, only water) for at least 9 hours? ○ Yes ○ No

CONSENT

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 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 page at the following URL, www.webmdhealth.com/pcb, 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.
Certification: I certify that the information supplied on this form is accurate and has been provided by me by my health care provider.

Participant Printed Name:_____ Date:_____

Participant Signature (required):_____

BIOMETRIC SCREENING INFORMATION

Date of Screening: (mm/dd/yyyy) __ __ / __ __ / __ __ __ __
(Acceptable Date Range: 12/1/2023 – 11/30/2024)

Blood Pressure: ___ / ___
Systolic / Diastolic

Height: ___ ___
Ft. Inches

Weight: ___ ___ ___
Lbs.

Waist: ___ ___
Inches

Glucose: ___ ___ ___

Total Cholesterol: ___ ___ ___

HDL: ___ ___ ___

LDL: ___ ___ ___

Triglycerides: ___ ___ ___

Physician Printed Name:_____ Physician Phone Number: _____

Physician Signature:_____

Submit form using one of the following methods:
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