## 2025 Erie 2CCB Primary Care Provider Form

1. 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 Information section using results obtained between 3/1/2025 and 3/31/2025 and sign the form.

4. Submit form once, using one method listed below. Forms must be submitted by 3/31/2025. Forms received after the deadline will not be accepted. a. Preferred Method: Securely upload online at https://www.totalwellnesshealth.com/gravity-landing/erie-2-ccb-pcp-form-online-upload/ b. Fax securely to 402-939-0458.

c. Mail to Total Wellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127. Forms must be received by 3/31/2025. Please allow time for mailing.

5. Within 5 business days of form submission, a confirmation email will be sent to the email listed below. If a confirmation email is not received after 5 business davs, please resubmit your form.

PARTICIPANT INFORMATION																												
Participar														icipant Last Name:														
Participant Date of Birth: (mm/dd/yyyy) P													Participant Unique ID:															
	/			/																								
Email: (Required to provide confirmation of form receipt.)																												
Gender:															01	Nale		OF	ema	le								
Have you fasted for at least 9 hours? (No food. Only water permitted.)															O Yes O No													
Are you p							,					,								O Yes O No								
BIOMETRIC SCREENING INFORMATION																												
Date of S	/			1		2025}				<b>Bloc</b> Systol		ressi	/	Diasto	lic		]	Heig Ft.	ght:	Inches	5		Weig	ght:			Wais Inches	t:
Glucose:	:				Tota	l Ch	oles	terol	:		HDL			]				: 		]			Trig	lycei	rides	:		
Physician	Physician Printed Name:												Physician Phone Number:															
Physician	Sig	natur	e:																									
CONSEN Disclosure of provide confii trends in heat transferred to GINA Notice rules, includin GINA Notice you other well other applica to the rapplica Your GINA P to waive the of be disclosed Certification regarding this	of Info dentia lth con a thir and A ng the and A llness ble law rotecte confid to you : I cer s infor	I service additions of party <b>Author</b> Genet uthoriz progra w. You ed Info entiality ir emplitify tha mation	ces to s and u y for re rization tic Info zation p um serv ur GIN, rmatio y of thi oyer ir t the ir	me ar portin <b>n.</b> Thi rmatic prior t vices. A Pro n will s info n aggr nforma	nd gath f servic g and/ s Scre on Non o unde The E tected not be rmatio regate ation s	her and ces. N or ince ening ndiscrir ergoing mploye Inform sold, e n as a terms upplied	onymo o pers entive f is part nination the S er Prog hation exchar condit that do d on th	ous state onal he tracking of my on Act ( Screeni gram sa will be nged or tion of o not di is form	tistical ealth ir g. employ ("GINA ng. Yo afegua disclose transfi particip isclose i is acc	data f nforma yers w "). Th ur Em rds Gl sed to erred, bating your curate	or my ation w vellnes ne resu ploye INA pr you a except in the specift and h	vill be p ss prog ults of f r Progr rotected and to bot to the Emplo ic iden as bee	any. I provide this So ram us d infor vendo e exter byer Proventity. en proventity.	under ed to m Emplo creenir ses GIN mation rs of yo nt requ rogram	stand y com g may NA Pro and w our En irred by o or as o me b	that m pany. ogram y be co otected vill not nploye y law t a con	ny bas Biom n"), wh onside d Infor t disclo er Prog to carr ndition health	ic stati netric d ich is a ered G matior ose any gram, f y out a of reco care p	stics v lata or NA Pr to he GINA or pur ictivitie eiving	vill be a person ntary w otected lp you A Prote poses es relate any inc er and t	aggreg hal ide ellness d Inforr unders cted In of proved to the centive hat To	ated a ntifiers progr mation stand y format viding y ne Emp . Your talWel	and pre (i.e. d ram ad . GIN your po tion, ex you wi ployer r GINA llness	esented ate of A requised otential ccept a th Emp Progra Progra Prote may co	d in rep birth, r ered ad ires tha l health s perm bloyer am. You cted In pontact n	ports name, ccordi at you n risks nitted Progr u will forma my pr	only to etc) man receive and to by GIN/ am serv not be a tion wil	show ay be deral e this offer A and vices. asked
Participant Printed Name:																Date	e:											
Participar	nt Się	gnatu	ire:							Submi	t form	usina	one of	f the fo	llowing	n moth	node:											
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