Raleigh Wellness 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 (fasting preferred) and take this form.
- 3. Ask your provider to complete the Biometric Screening Information section using results obtained between 8/1/2024 and 8/8/2025 and sign the form.
- 4. Submit form once, using one method listed below. Forms must be RECEIVED by 8/8/2025. Forms received after the deadline will not be accepted.
 - a. Securely upload online at https://www.totalwellnesshealth.com/gravity-landing/raleigh-upload/ (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 8/8/2025. 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: (Required for Employees only)
Email: (Required to provide confirmation of form receipt.)	
Gender:	O Male O Female
Have you fasted (no food, only water) for at least 8 hours?	O Yes O No
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)	Height: Weight: Waist: Diastolic Ft. Inches Lbs. Inches LDL: Triglycerides: BMI:
Provider Printed Name:	Provider Phone Number:
Provider Signature:	