



## 2025 Physician Form

## Instructions:

- 1. Each participant must complete and submit their own form separately, including employee ID or Spouse ID, email and sign the form.
- 2. Visit your health care provider for a Health Screening, print and take this form to your appointment. The cost of the lab tests listed on this page will only be covered if included as part of an annual preventive wellness exam.
- 3. Ask your provider to complete the Health Screening Information section using results obtained between 1/1/2025 and 9/30/2025 and sign the form.
- 4. Submit form once, using one method listed below. Forms must be received by 9/30/2025. Forms received after the deadline will not be accepted.
  - a. Securely upload (preferred method) online at www.Lllvewell.com
  - b. Fax securely to 402-939-0772.
  - c. Mail to Total Wellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127. Forms must be received by 9/30/2025; please allow time for mailing.
- \*\*It is your responsibility to make sure that your form is submitted by the deadline.
- 5. Within 48 hours of form submission, 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 www.Ll/vewell.com.

PARTICIPANT INFORMATION	
Participant First Name:	Participant Last Name:
Participant Date of Birth: (mm/dd/yyyy)	Employee ID/Employee ID +Spouse DOB (EX: 12345MMDDYYYY):
Email: (Required to provide confirmation of form receipt.)	
Gender:	O Male O Female
Have you fasted for at least 9 hours? (No food. Only water & prescribed medication)	. ,
Are you pregnant? (Females Only)  **If 'Yes' please fill out Pregnancy Waiver form and submit it by 11/28/2025	O Yes O No
HEALTH SCREENING INFORMATION	
Date of Screening: (mm/dd/yyyy)          /	Height: Weight: Waist:  Diastolic Ft. Inches Lbs. Inches
Glucose: Total Cholesterol: HDL:	LDL: Triglycerides: BMI:
Physician Printed Name:	Physician Phone Number:
Physician Signature (required):	
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 online Wellness 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 www.LilveWell.commy 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 Health Screening is part of my employer's wellness program ("Employer Program"), which is a voluntary wellness program administered according to federal rules, including the Genetic Information. GINA requires that you receive this GINA Notice and Authorization prior to undergoing the Screening. Your Emp	
Participant Printed Name:	Date:
Participant Signature (required):	

Submit form using one of the following methods: Securely upload (preferred method) online at <a href="https://www.LilveWell.com">www.LilveWell.com</a> | Fax to 402-939-0772 Mail to: TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127- Form must be received by 9/30/2025