WELL WISCONSIN
Healthier starts with you

STAYWELL

Complete this form using results from your most recent health care provider visit to earn credit for the 2020 Well Wisconsin Program. **The form must be submitted by October 9, 2020**. You may choose to attend a Well Wisconsin on-site health screening instead of submitting this form. Log onto wellwisconsin.staywell.com to learn more.

Step 1: Enter your name and date of birth.

Step 2: Review the consent language, sign and date.

Step 3: Enter the screening values from your most recent health care provider visit.

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 insurer to confirm these labs will qualify for a preventive service benefit.

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 10/9/2020.

- Fax at 240-477-1521
- Mail it to US Wellness at 20400 Observation Drive #100, Germantown, MD 20876
- Securely upload it electronically at https://wellwi.uswellness.com/offsite

Questions?

Contact the StayWell Helpline at 1-800-821-6591 or wellwisconsin@staywell.com

HEALTH CARE PROVIDER FORM – WELL WISCONSIN PROGRAM

Complete Steps 1-4 on this form to verify that you are current on your preventive healthcare. Submit this form by October 9, 2020. Print clearly.

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

First Name

Last Name

Date of Birth (Month Day Year)

Phone Number

E-mail address

STEP 2: Complete

I understand that StayWell and US Wellness, Inc. may use and disclose my personally identifiable information and screenings results collected on this form (my "Personal Information"), in order to provide wellness program services to me, on behalf of the sponsoring entity. Except for my actual screening results, StayWell may provide my Personal Information to my sponsoring entity or its designated representative to (I) notify them of whether I am eligible for the incentive, and/or (ii) provide them with program participation information. StayWell and US Wellness, Inc. may use my Personal Information for anonymous group statistical research and analysis and may combine my Personal Information with information collected from other participants to create anonymous aggregate data reports. StayWell may provide my Personal Information to (I) my health plan or its vendors for purposes of treatment, payment, and health care operations, including benefits administration, appeals, and incentive management, and (ii) the plan sponsor of my health plan for plan administration functions in accordance with the 45 C.F.R. 164.504. The Well Wisconsin Program ("Program") is a voluntary wellness program administered per the Genetic Information Nondiscrimination Act ("GINA") and other applicable law. If you participate in the Program, you will be asked to complete a voluntary health risk assessment, which requests certain information, including whether you have ever had certain medical conditions, diseases or disorders ("Protected Information"). The Program uses Protected Information to help you understand potential health risks and to offer disease management programs, coaching and other services. The Program safeguards the privacy and security of any Protected Information you provide consistent with applicable law. Protected Information may be disclosed to you and any licensed health care professionals or board certified genetic counselors to provide you with Program services and will not be sold, exchanged, transferred or otherwise disclosed, except as permitted by law to carry out Program-related activities. You will not be asked to waive the confidentiality of this information as a condition of participating in the Program or receiving any incentive. No Protected Information will be used in making any employment decision and such information will be disclosed to your employer only in aggregate terms that do not disclose your specific identity.

X _____

Participant Signature Authorizing Disclosure (REQUIRED) **Date**

STEP 3: Complete

PREGNANT ◯ **Yes** ◯ **No**

REQUIRED VALUES

Blood Pressure

Systolic /

Diastolic

Date of Test

(Month) (Day) (Year)

Height

(Feet) (Inches)

Weight (lbs)

Date of Measurement

(Month) (Day) (Year)

ADDITIONAL VALUES* (if recommended by your doctor)

Cholesterol

Total Cholesterol

HDL Cholesterol

LDL Cholesterol

Triglycerides

Were you fasting for more than 8 hours prior to this test? ◯ Yes ◯ No

Date of Test:

(Month) (Day) (Year)

Glucose (Blood Sugar)

Were you fasting for more than 8 hours prior to this test? ◯ Yes ◯ No

Date of Test

(Month) (Day) (Year)

*Please note, you may be responsible for out of pocket costs associated with these lab tests.

Health Care Provider Name Health Care Clinic Phone Number

STEP 4: Submit Form by 10/09/2020

Participant may fax this form to 240-477-1521, mail it to US Wellness at 20400 Observation Drive #100, Germantown, MD 20876 or securely upload it electronically at https://wellwi.uswellness.com/offsite. If you entered your email address, you will receive verification that your form has been received within two business days.