MHealthy Rewards 2019 Health Care Provider Form

STAYWELL.

Instructions:

1. Determine if you have had your height, weight, blood pressure, total cholesterol and HDL cholesterol tested at your health care provider between April 1, 2018 and April 1, 2019.

   If **No**, please disregard this form and attend an on-site Rewards Wellness Screening. To schedule an on-site screening appointment, go to mhealthy.umich.edu/rewards and log into the StayWell Portal. Click on the Wellness Screening block.

   If **Yes** to the above, please complete all participant information, including email and signature at the very bottom of this form.

2. Ask your provider to complete the Biometric Screening Information section using results obtained between 04/01/2018 and 04/01/2019. Please note: you are responsible for any fees associated with having this form completed by your physician / physician's office.
3. Submit form once (see bottom of form for Secure Upload or Fax #). Forms must be RECEIVED by **04/01/2019**. Forms received after the deadline will not be accepted.

   Within 48 hours of form submission, a confirmation email will be sent to the email provided below. If a confirmation email is not received within 48 hours, please resubmit your form or contact your physician's office. StayWell is not responsible for forms not received before the deadline.
4. Please allow 10 business days for the information to be available on the StayWell Portal and for your activity to be marked as complete.

PARTICIPANT INFORMATION

Participant First Name:

Participant Last Name:

Participant Date of Birth: (mm/dd/yyyy) / /

Participant 8 Digit UM ID (no spaces):

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

BIOMETRIC SCREENING INFORMATION (completed by Physician)

Date of Screening: Month / Day / Year

Blood Pressure: Systolic / Diastolic

Height: Ft. / Inches

Weight: Lbs.

Total Chol:

HDL Chol:

Was the patient fasting for at least 9 hours? (*No food. Only water permitted.*) O Yes O No

Was the patient pregnant when values were collected? O Yes O No

Physician's Printed Name:_____ Physician's Phone Number:_____

Physician's Signature:_____

CONSENT

Disclosure of Information. I understand that the information submitted on this form (my "Personal Information") will be transferred to StayWell by TotalWellness. My Personal Information is used by StayWell 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 StayWell or by another service contractor. In the event that StayWell's services are transitioned to another service provider, StayWell may deliver my Personal Information to the successor provider to maintain a continuity of services for me. In order to distribute any incentives, StayWell 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. StayWell 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 StayWell. Except for these types of usage and the uses specified in my StayWell Online terms of use, my Personal Information will not be disclosed by StayWell. StayWell 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"). StayWell will comply with the HIPAA to the extent applicable.

GINA Notice and Authorization. This 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 Nondiscrimination Act ("GINA"). The results of this Screening may be considered GINA Protected Information. GINA requires that you receive this GINA Notice and Authorization prior to undergoing the Screening. Your Employer Program uses GINA Protected Information to help you understand your potential health risks and to offer you other wellness program services. The Employer Program safeguards GINA protected information and will not disclose any GINA Protected Information, except as permitted by GINA and other applicable law. Your GINA Protected Information will be disclosed to you and to vendors of your Employer Program, for purposes of providing you with Employer Program services. Your GINA Protected Information will not be sold, exchanged or transferred, except to the extent required by law to carry out activities related to the Employer Program. You will not be asked to waive the confidentiality of this information as a condition of participating in the Employer Program or as a condition of receiving any incentive. Your GINA Protected Information will only be disclosed to your employer in aggregate terms that do not disclose your specific identity.

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:_____

Submit form using one of the following methods:

Securely upload online at https://www.totalwellnesshealth.com/gravity-landing/umich2019/ OR Fax to: 402-939-0604