2021 Kentucky Employees' Health Plan Biometric Screening Form

Instructions

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. This form is intended to be used at your wellness exam with your provider, pharmacy locations, and Premise Health onsite clinics.
4. Ask your provider to complete the Biometric Screening Information section using results obtained between 1/1/2021 and 7/1/2021 and sign the form.
5. Submit form once, using one method listed below. Forms must be RECEIVED by **7/15/2021**. Forms received after the deadline will not be accepted.
   a. Securely upload online at **https://totalwellnesshealth.com/gravity-landing/KEHP/ (preferred method).**
   b. Fax securely to 402-939-0604.
   c. Mail to TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127. Forms must be received by 7/15/2021. Please allow time for mailing.
6. 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.
7. Please allow 10 business days for the information to be available on the portal.

Who is eligible to submit this form?

1. **Current KEHP Plan holders, waivers, and spouses on a cross-reference payment plan. (Spouses / dependents are not eligible) (Must be over age 18)**
2. **Participants who have not received a screening from 1/1/21 – 12/17/21**

PARTICIPANT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: (mm/dd/yyyy) __ __ / __ __ / __ __ __ __ Unique ID (last 4 of SSN): _____

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

Gender:	O Male	O Female
Have you fasted for at least 8 hours? (*No food. Only water permitted.)*	O Yes	O No
Are you pregnant? *(Females Only)*	O Yes	O No

BIOMETRIC SCREENING INFORMATION

Date of Screening: (mm/dd/yyyy) __ __ / __ __ / __ __ __ __ (Acceptable Date Range: (1/1/2021-12/17/2021)

Height: ___ Ft. __ __ In.

Weight: ___ Lbs.

Waist: __ __ In.

BMI: __ __ . __

Glucose: ___

Total Cholesterol: ___

HDL: ___

LDL: ___

Triglycerides: ___

Blood Pressure: ___ / ___ Systolic / Diastolic

Clinician Printed Name:_____ Clinician Phone Number:_____

Clinician Signature:_____

CONSENT

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 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 at KEHPlivingwell.com respectively, 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: By signing this form, I certify that the information supplied on this form is accurate and has been provided by me or by my health care provider.

Participant Printed Name:_____ Date:_____

Participant Signature:_____

Submit form using one of the following methods:
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