2023 Kentucky Employees' Health Plan Biometric Screening Form

TEAM KENTUCKY PERSONNEL CABINET | Kentucky Employees' Health Plan

Instructions

1. Complete all member 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 onsite LivingWell Health clinics
4. Ask your provider to complete the Biometric Screening Information section using results obtained between 1/1/2023 and 12/15/2023 and sign the form.

If you would like to have your screening count towards the LivingWell Promise the screening values must be collected on or before 7/1/2023

5. Submit form once, using one method listed below. Forms must be RECEIVED by **12/15/2023.** 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 7/15/2023. 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 and medically enrolled spouses enrolled in health insurance coverage. (Must be 18 or over)**
2. **Members who have not received a screening from 1/1/23 – 12/15/23**

MEMBER 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: ○ **Male** ○ **Female**

Have you fasted for at least 8 hours? (*No food. Only water permitted.*) ○ Yes ○ No

Are you pregnant? ***(Females Only)*** ○ **Yes** ○ **No**

BIOMETRIC SCREENING INFORMATION

Date of Screening: (mm/dd/yyyy) / /

(Acceptable Date Range: (1/1/2023-12/15/2023)

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.

GINA Notice and Authorization. This screening is part of your 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 information protected under GINA ("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 the 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 permitted 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: 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:_____