Physician Form Completion Instructions

Thank you for ordering the Physician Form. To meet applicable reward requirements, the biometric results documented on this form must be current (obtained since December 1, 2020).

COMPLETE THE FORM

- **Participant:** Complete the **Participant Information** section of the Screening Results Page. Print legibly using a blue or black pen. Sign and date the Form in the areas provided.

  Note: The Form cannot be processed without the Participant signature.
  Note: Do not alter the prepopulated information on the form. Doing so will cause the form to not process appropriately**.**

- **Physician:** Complete the **Biometric Measurements and Physician** Information sections of the Form:

  - *Biometric Measurements and Blood Test Results* **-** Provide biometric measurements and blood test results using data collected since December 1, 2020. Standard methods to obtain the Biometric Measurements are described on the Form. Please fill in the boxes and the corresponding bubbles below the boxes.

  - *Physician Information* **-** Complete this section, sign and date the Form in the areas provided.
    Note: The Form cannot be processed without the Physician's information.

RETURN THE FORM

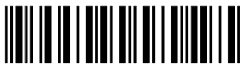
Please make a copy of the completed form for your records. **The Form must be completed and returned by 11/30/2021 by 11:59pm CST.**

Mail the completed Form to: **WiseTREND, P.O. Box 361290, Milpitas, CA 95036-1290.**

-- OR --

Fax the completed Form to 615-823-1075. This is a secure fax. Please keep your fax confirmation as record that the form was faxed successfully.

Please Note:
If any of the data fields in the Physician Information section are incomplete, you may need to return to your physician's office to obtain the missing data. If you have any questions regarding the process, please contact Sharecare Customer Support at 1 (800) 268-5703.



52866-PRID

LAB CODE | P | O | L | A |

FOR PARTICIPANT USE ONLY

Participant Information

We will be unable to process this form if the pre-printed participant information below is altered.

Member ID (for HW use only)

Last Name

Date of Birth: / /

First Name

Gender ○ M ○ F

I, the above named participant, have read, understand and agree to the terms on the Wellness Notice and Consent attached to this form. No attempts by the participant to modify or amend this form will change such terms or in any way be binding upon Sharecare.

Signed ______________________________ Date / /

Fold here

Participant signature REQUIRED in order to process.

FOR PROVIDER USE ONLY

Biometric Measurements

PROVIDER COMPLETE THIS BOX

Document ALL measurements in this written section and ensure you fill in the bubbles under each measurement completely. Please use blue or black ink and do not use X's to indicate your responses in the bubble section.

Hours Fasted

Height (Obtained without shoes, measured to the nearest ¼ inch) ft in.

Feet: 3 ○, 4 ○, 5 ○, 6 ○, 7 ○
Inches: 1–9, 0 (two columns of bubbles)
○ 1/4 ○ 1/2 ○ 3/4 ○ even — shade one above

Waist Circumference (Measured at the navel. Round down to the nearest inch) in.

Total Cholesterol mg/DL

LDL mg/DL

Fasting Glucose mg/DL

Weight lbs.

Blood Pressure (Obtained at rest) / mm/HG

Fold here

HDL mg/DL

Triglycerides mg/DL

FOR PROVIDER USE ONLY

Provider Information

PROVIDER COMPLETE THIS BOX **Provider please complete ALL fields below.**

Signature Date / /

Provider Signature ______________________________

Provider Signature is REQUIRED

Provider's Name

Date of Service / /

Medical License #

State of License

Telephone # - - Ext.

Mail One Signed Copy to:
WiseTREND
PO Box 361290
Milpitas, CA 95036-1290

Fax Secure to: 615-823-1075
Or
Scan and upload your form at
https://psf.abbyyusa.com/psf

Participant
Keep One Copy for Your Records

Wellness Notice and Consent

I agree to participate in Sharecare' Health Risk Screening and Support Program (the "Program"). I understand the Program is offered by my health plan or my employer as the sponsor of my health plan ("Sponsor"). I understand that completion of this biometric screening is voluntary. If I choose not to participate or do not give my permission by signing this authorization form and completing this screening, I understand that I may not be able to receive Program incentives (if offered). The biometric screening data includes data which may be considered genetic information. I further understand that if choose to participate in the screening, any health and genetic information obtained in the screening will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program.

The Program may include identifying my unique behaviors (biometric measurements), completing a health risk or well-being assessment or other wellness activities, and giving lab results from a recent blood test with my physician or healthcare provider. The blood tests include but are not limited to: Total Cholesterol, High Density Lipoprotein (HDL), Low Density Lipoprotein (LDL), Triglycerides, Glucose, and Cotinine. This collection may also include recording of biometric measurements of Height, Weight, Waist Circumference, Blood Pressure and Body Mass Index (BMI).

I give my permission for my physician or healthcare provider to give Sharecare results from my blood sample and lab study performed within the past six (6) months to twelve (12) months, for the tests listed on this form. I agree to sign any authorization form (permission form) required by my physician or healthcare provider to give these results to Sharecare. Also, I release Sharecare and other companies or people working with the Program from any and all liability coming from the report of the study of my blood sample.

I understand that all information and comments I receive through the Program are based on the brief review that has taken place, and are NOT a medical diagnosis or opinion. Participation in the Program does not take the place of professional medical advice. I must call or visit my doctor to talk about any questions I have about my test, screening, or lab results or to get medical opinions.

I understand and give my permission for Sharecare to use and share my personal health information as allowed by law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). My personal health information may have my name, participation status, screening results and other information. I also give my permission for Sharecare to share my information with my Sponsor or benefit provider in order to operate the Program and with other programs offered by my Sponsor to provide wellness services to me.

Sharecare may depend on my permission for as long as I participate in the Program. I may revoke this permission at any time by writing to Sharecare. The removal of my permission does not apply to any use or sharing of my information by Sharecare before I write to them. Any notice to Sharecare should be mailed to Sharecare, 701 Cool Springs Blvd., Franklin, TN 37067, Attn: Privacy Officer.