Wellscreens 2026 Fax Form

WELLSCREENS FAX FORM INSTRUCTIONS: UAB employee completes Section 1. Health care provider completes Section 2. See instructions for submitting form below. Biometric screening must be submitted by **11/30/2026** to receive completion credit or incentive (if applicable).

SECTION 1: PARTICIPANT INFORMATION (print clearly — illegible forms will not be processed)

PARTICIPANT DATE OF BIRTH

SEX: M F

BLAZER ID

PARTICIPANT FIRST NAME

MI

PARTICIPANT LAST NAME

ADDRESS

UNIT/APT.

CITY

STATE

ZIP CODE

EMAIL ADDRESS

PHONE NUMBER

DATE

PARTICIPANT SIGNATURE

PLEASE READ THE FOLLOWING DISCLOSURE STATEMENT: I understand that my health screening data will be released to health plans associated with my company for the purpose of follow-up health education and disease management counseling (if eligible). My individually identifiable health information will not be shared with my Employer: however my Employer may be advised of the fact of my participation in this health screening for purposes of qualification for incentives offered by my Employer. In addition, if my Employer offers incentives related to "pass/fail" test results, my "pass/fail" test results may be disclosed to my Employer for those incentive purposes. My health screening test results may be disclosed to vendors engaged by my Employer or Employer- sponsored group health plan for purposes of determining my eligibility for an incentive related to this health screening, for health management and/or disease management services including data aggregation for program improvement purposes, and/or for purposes of population of my Personal Health Record available online and/or my Health Risk Assessment (HRA). The importance of safeguarding individually identifiable health information is recognized and all organizations involved in this Biometric Health Screening are obligated to take reasonable steps to protect such information from unauthorized access or use.

SECTION 2: Health care provider only to complete below this line

MESSAGE TO HEALTH CARE PROVIDER: UAB is offering a voluntary wellness program to encourage participants to understand their health risk. Measurements will not qualify if taken prior to 1/1/2026. This form must be completed in its entirety, accurately and legibly in order to be deemed complete. **Reminder to Provider: Are there any annual screenings your patient is now eligible for or needs a reminder about?**

HEIGHT: FT IN

TC:

HDL:

LDL:

WEIGHT: LBS

GLUCOSE:

RATIO:

TG:

BMI:

A1C: (OPTIONAL)

SYSTOLIC BP:

DIASTOLIC BP:

IS PARTICIPANT CURRENTLY FASTING? ◯ YES ◯ NO

CURRENTLY PREGNANT OR PREGNANT IN THE LAST 12 MONTHS? ◯ YES ◯ NO

GETS AN AVERAGE OF 75-150 MIN OF PHYSICAL ACTIVITY A WEEK? ◯ YES ◯ NO

FACILITY NAME

FACILITY PHONE NUMBER

DATE OF SERVICE/TEST

PROVIDER NAME

PROVIDER SIGNATURE

DATE

SUBMIT FORM

You or your provider may submit the **completed and signed form** in one of the following ways:

- Upload a scanned copy through a secure REDCap link at https://redcap.link/uabew or by using the QR code.
- Fax the form directly to UAB Health Smart at **888-257-0073**.