CARE
A UMR Solution

UMR CARE Physician Lab Form Instructions

Participant instructions

1. Schedule an appointment with your health care provider.
2. Prior to your appointment, verify your provider can measure all required biometric screenings (height, weight, blood pressure, total cholesterol, waist measurement and blood glucose or A1c if you are a diagnosed diabetic or have a medical condition that doesn't allow fasting).
3. Review and validate your personal information printed on the Physician Lab Form.
4. Sign the Physician Lab Form next to **Participant Signature**.
5. Remember to fast 9-12 hours before your screening. You can still drink water and take your normal medications while fasting.
6. Bring the Physician Lab Form with you to your appointment. Give the Physician Lab Form to your provider to complete the Vitals and Labs section of the form. All required fields must be completed for your form to be processed.
7. Only the UMR Physician Lab Form can be accepted and processed. Faxing or uploading any other form will not be accepted.

Returning the form

Fax the completed Physician Lab Form (or have your provider fax it) to **515-608-4589**. It is your responsibility to ensure the form is complete and submitted correctly prior to the deadline.

OR

Upload using the link on your wellness portal under the **Resources** widget. Select **Upload Physician Lab Form**. Choose the file from your computer and upload the completed form.

Please keep a copy of your completed Physician Lab Form, as well as the fax confirmation.

Note: Your Physician Lab Form will be processed within 5 business days of the date it is received. Please sign in to **umr.com** to confirm whether your results have been processed successfully or additional information is needed. After signing in, select **Health center** on your member home page, then choose the **Wellness activity center** to get started. Next, check the **Messaging** inbox for processing information or view your **Lab results and health records** (select "Medical History" to see your results).

Provider instructions

- Complete the **Vitals and Labs** section of the form.
- **Note:** An A1c test is recommended in place of the glucose test for people diagnosed with diabetes.
- Sign and date the form, then enter your office address details and telephone number.
- You may use an office stamp in place of manual entry of office address.
- Ensure all required tests and fields are completed for processing.
- Confirm with the participant that you will fax the Physician Lab Form to **515-608-4589** or determine a process for the participant to pick up their form after the results have been recorded for them to submit.
- Only the UMR Physician Lab Form can be accepted and processed. Faxing or uploading any other form is not acceptable.

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How we protect your information

Your employer has offered you the opportunity to participate in their wellness program offered by UMR. This form is used to capture your biometric screening results obtained by your health care provider. Before you participate in a biometric screening, we would like to provide you with some information about the health information we may obtain from your screening, how and why we use it, and how we protect it.

You are not required to participate in the biometric screening. Participation is completely voluntary. If you choose to participate, you may receive incentives and/or information on services to help you manage your health. If you choose not to participate, you may not receive program incentives if offered by your health plan for participation in such health and wellness programs.

How do we use, share and protect your information?

- The health information obtained through your biometric screening is shared with your benefits administrator, UMR, for the purposes of plan administration:
  - o UMR may share your information with their wellness coaches and nurses who are involved in administering your wellness and condition management programs.
  - o UMR may use your information to generate incentive rewards associated with your biometric screening.
- Your employer (or spouse's employer) will not receive your results in any form that may match the data to you. However, your employer's benefits plan, which may be self-administered, may receive identifiable information for purposes of managing the benefits plan or administering incentives on your behalf. If your employer or program sponsor selects additional health benefits management services as part of this wellness screening, then, at the direction of your employer or program sponsor, your data may be shared with health care professionals/companies and/or your employer's Group Health Plan representatives who offer additional services provided by your employer. Data sharing with authorized third parties will be performed via a secure data exchange process designed to keep your personal and protected health information secure. In no event will UMR sell, exchange, or otherwise disclose your data, except as stated in these Terms of Service.
- Your health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan administrator or health care provider, the information may no longer be protected by the Federal privacy regulations.
- We take reasonable precautions to protect data and to avoid data breaches, including maintaining physical, technical, and administrative safeguards. In the event of a data breach involving information you provide in connection with the wellness program, we will notify you within the time periods required by applicable laws, including Health Insurance Portability and Accountability Act (HIPAA).

By completing your biometric screening, and authorizing your physician to send your results to UMR, you agree to the following:

- I affirm that I have read and understood this authorization.
- I understand that participation in any programs noted above is completely voluntary.
- I agree that if I choose to participate in any programs noted above, I authorize the collection and use of my data as described in this authorization.
- I understand that the program is offered by my health plan or my employer acting as the sponsor of my health plan. If my health plan implements an incentive as part of the program, I consent the authorized representatives of the program informing my health plan or my employer acting as the sponsor of my health plan whether or not I qualify for such incentive based upon my participation in the program. I understand that if I do not elect to provide such consent, I may not qualify for such incentive.

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Eligible screening dates ____/____/____ (MM DD YYYY) **to** ____/____/____ (MM DD YYYY)

Date of screening* ____/____/____ (MM DD YYYY) **Fasting*** ◯ **Non-fasting*** ◯

Program participation requires tests and measurements be taken and then completed.
Physician Lab Form should be faxed to **515-608-4589** within the eligible timeframe.

SECTION 1: Personal information

Participant name _____

Date of birth ____/____/____ (MM DD YYYY) Phone number ____-____-____

Email address _____

SECTION 2: Vitals and labs

Height* _____ ft. _____ in. Weight* _____ lbs. Waist measurement* _____ in.

Blood pressure* _____ / _____ mmHg

LDL* _____ mg/dL HDL* _____ mg/dL _____ mg/dL

Total cholesterol* _____ mg/dL Triglycerides* _____ mg/dL

Blood sugar* _____ mg/dL *or* A1C *(for diabetes only)* _____ %

Provider stamp or signature

Provider name _____

Date of birth ____/____/____ (MM DD YYYY) Phone number ____-____-____

Patient signature _____ Date ____/____/____ (MM DD YYYY)

Fields with asterisks (*) are required