BlueCross BlueShield Arizona

USWellness

2023-2024 PCP Form

If you have received the health tests listed below from a health care provider on or after 8/1/23, you may have the provider complete the bottom part of this form to receive credit in Knight Transportation's wellness program. Please scan and upload your completed form onto the registration page on or before **12/31/24**. Receipt of your form will be confirmed within two business days to the email provided below (please print clearly and allow emails from uswellness.com).

First Name: Last Name: DOB:

I understand that any individually identifiable health information about me obtained in the course of this screening may be released to and maintained by US Wellness. I authorize US Wellness to share my individually identifiable health information for the purpose of providing wellness services and/or the purpose of aggregate population health analysis. I understand that my information will not be shared with my employer. I authorize that US Wellness and their partners may contact me and that my information will be managed in accordance with the uses and disclosures permitted of covered entities under the federal HIPAA Privacy Rule. I may revoke this authorization through written communication to privacy@uswellness.com. Revocation of this consent will apply to data sharing that has not yet occurred at the time of the revocation.

Participant signature:_____Date:_____

To be completed by physician office

PREGNANT ☐ Yes ☐ No

Cholesterol

Total Cholesterol ☐☐☐

HDL Cholesterol ☐☐☐

LDL Cholesterol ☐☐☐

Triglycerides ☐☐☐

Patient fasting?

☐ Yes ☐ No

Date of Test:

☐☐ (Month) ☐☐ (Day) ☐☐☐☐ (Year)

Glucose ☐☐☐ or HbA1c ☐☐.☐

Patient fasting?

☐ Yes ☐ No

Date of Test:

☐☐ (Month) ☐☐ (Day) ☐☐☐☐ (Year)

Waist Circumference

☐☐.☐

Date of Measurement:

☐☐ (Month) ☐☐ (Day) ☐☐☐☐ (Year)

Blood Pressure

Systolic ☐☐☐

Diastolic ☐☐☐

Date of Test:

☐☐ (Month) ☐☐ (Day) ☐☐☐☐ (Year)

Height: ☐☐ (Feet) ☐☐ (Inches)

Weight(lbs): ☐☐☐

Date of Measurement:

☐☐ (Month) ☐☐ (Day) ☐☐☐☐ (Year)

Cotinine: Positive ☐ Negative ☐

Date of Measurement (MM/DD/YYYY): _____/_____/_____

*Required to remove the tobacco surcharge. Please attend an onsite screening event or visit a lab if your PCP cannot perform this test.

Healthcare provider name: Phone:

Healthcare provider signature: Date: