Wellness Program Forms

Wellness Program Forms and Directions for Use

Annual Physical Form - Throughout the year schedule an annual physical with your primary care provider. Take this form to the appointment and have it completed and signed by your provider. The medical plan covers the cost for an in-network routine annual wellness physical exam.

Important! *Please communicate to your doctor that you are there for your routine annual preventive care exam and to process as a preventive care exam so that you are not charged for the visit. Your insurance plan covers one free preventive care exam per 12 months.*

Biometric Screening Form – Use this form to capture your screening results completed through a family doctor/primary care provider instead of the worksite health screening. Take this form to the appointment and have it completed and signed by your provider.

Medical Exemption Form – Use this form to submit if you are unable to meet the goals of the wellness program due to a medical condition, physical or mental disability, recent pregnancy, or if your primary care provider declares it is medically inadvisable. Take this form to the appointment and have it completed and signed by your provider.

Reasonable Accommodation Form – If you choose to use your Primary Care Provider for your Reasonable Accommodation, please have them complete and sign this form. If you choose to complete 3 visits with one or any combination of your Wellness Coach or RD, you will not need this form. Your provider team will track and report completion of visits.

All forms can be securely submitted to Ramp Health through the Ramp Health Digital Platform.

Return Forms by July 31, 2024 – No Extensions

Upload via the Ramp Health Platform – You can easily use your smartphone to capture a picture of the form or upload as an attachment. If you need assistance submitting your form, contact support@ramphealth.com

Annual Physical Form

Ramp Health has provided our clients a medical form for the purposes of verifying annual wellness exams.
The medical plan covers the cost for an in-network routine annual wellness physical exam.
IMPORTANT! *Please communicate to your doctor that you are there for your routine annual preventive care exam and to process as a preventive care exam so that you are not charged for the visit.*

All fields must be completed; if any fields are left blank it will delay the processing of this information.
To be completed by the participant:

Last Name: _____First Name: _____MI: _____

Address: _____

State: _____ Zip Code (of home address): _____ Date of Birth (MM/DD/YYYY):_____

Gender (circle): Male Female

Circle One: Employee Spouse

Last 4 digits of SS# _____ **E-mail: _____**

Company: _____ **Phone: _____**

I authorize my healthcare provider to release the requested information to Ramp Health in compliance with my employer's voluntary wellness program:
Signature: _____ Date: _____

To be completed by the provider or you may attach your test results or care summary:

I confirm that the above named is:

☐ Has undergone an annual physical based upon their age and gender requirements.

I confirm the information provided is accurate:
Provider Signature: _____ Date: _____

Provider Printed Name: _____ Facility: _____

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Reasonable Accommodation Form

Ramp Health has provided our clients a medical form for the purposes of verifying that you are consenting to participate in the voluntary employee wellness program.
All fields must be completed; if any fields are left blank it will delay the processing of this information.
To be completed by the participant:

Last Name: _____First Name: _____MI: _____

Address: _____

State: _____ Zip Code (of home address): _____ Date of Birth (MM/DD/YYYY):_____

Gender (circle): Male Female

Circle One: Employee Spouse

Last 4 digits of SS# _____ **E-mail: _____**

Company: _____ **Phone: _____**

I authorize my healthcare provider to release the requested information to Ramp Health in compliance with my employer's voluntary wellness program:
Signature: _____ Date: _____

I confirm that I am working with the above individual to make lifestyle changes in at least one of the following areas to help reduce potential long-term health issues.

- Blood Glucose
- Cholesterol/LDL/HDL/Triglycerides
- Blood Pressure
- BMI
- Waist Circumference

I confirm the information provided is accurate:
Provider Signature: _____ Date: _____

Provider Printed Name: _____ Facility: _____

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Medical Exemption Form

Ramp Health has provided our clients a medical form for the purposes of verifying that your Physician releases you from the program requirements due to a medical condition.
All fields must be completed; if any fields are left blank it will delay the processing of this information.
To be completed by the participant:

Last Name: _____First Name: _____MI: _____

Address: _____

State: _____ Zip Code (of home address): _____ Date of Birth (MM/DD/YYYY):_____

Gender (circle): Male Female

Circle One: Employee Spouse

Last 4 digits of SS# _____ **E-mail: _____**

Company: _____ **Phone: _____**

I authorize my healthcare provider to release the requested information to Ramp Health in compliance with my employer's voluntary wellness program:
Signature: _____ Date: _____

To be completed by the provider:

I confirm that the above named is:

☐ Under my care and it is medically inadvisable/unreasonably difficult for them to participate in the wellness screening and earn associated rewards.

☐ Currently pregnant of has given birth in the last 12 months
You may also submit a copy of the baby's birth certificate, proof of hospital stay or pregnancy related test results

Describe the accommodation being requested: _____

I confirm the information provided is accurate:
Provider Signature: _____ Date: _____

Provider Printed Name: _____ Facility: _____

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Biometric Screening Form

Ramp Health has provided our clients a medical form for the purposes of verifying their individual screenings.
All fields must be completed; if any fields are left blank it will delay the processing of this information.
To be completed by the participant:

Last Name: _____First Name: _____MI: _____

Address: _____

State: _____ Zip Code (of home address): _____ Date of Birth (MM/DD/YYYY):_____

Gender (circle): Male Female

Circle One: Employee Spouse

Last 4 digits of SS# _____ **E-mail: _____**

Company: _____ **Phone: _____**

I authorize my healthcare provider to release the requested information to Ramp Health in compliance with my employer's voluntary wellness program:
Signature: _____ Date: _____

To be completed by the provider or you may attach your test results:

Height (Feet/Inches): _____ Total Cholesterol: _____
Weight (lbs.): _____ Triglycerides: _____
BMI or Body Fat %: _____ HDL: _____
Waist Circumference _____ LDL: _____
Blood Pressure _____ Glucose (fasting): _____

I confirm the information provided is accurate:
Provider Signature: _____ Date: _____

Provider Printed Name: _____ Facility: _____

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