Wellness Program Forms

Wellness Program Forms and Directions for Use

Annual Physical Form – The Annual Physical Form is used to document proof of completion of your routine annual physical exam with your Primary Care Provider (PCP). This exam includes **age- and gender-appropriate blood work** as determined by your PCP.

- **How to Use:**
  - Schedule your annual physical with your PCP.
  - Take this form to your appointment and have your provider complete and sign it to confirm the exam, including any necessary blood work.
  - Submit the completed form to your Wellness Coach or through the designated platform to fulfill this program requirement.

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 – The Biometric Screening Form is used to document the results of your biometric health screening, which includes **age- and gender-appropriate blood work** as ordered by your Primary Care Provider (PCP) or another medical health provider.

- **How to Use:**
  - Schedule an appointment with your PCP or health provider for your annual physical.
  - Bring this form to the appointment to have your provider document your biometric screening results, including any required blood work based on your age and gender.
  - Ensure the form is completed and signed by your provider.
  - Submit the completed form to your Wellness Coach or through the designated platform to fulfill this requirement.

Medical Exemption Form – This form is used to document situations where 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 determines it is medically inadvisable to participate.

- **How to Use:** Take this form to your primary care provider, have it completed and signed during your appointment, and submit it to your Wellness Coach or through the designated platform to qualify for the Wellness Incentive.

All forms can be securely submitted to Ramp Health through the Ramp Health Digital Platform. You can also share them with your Wellness Coach during your Coaching session.

Return Forms by July 31, 2025 – 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

Ramp Health

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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Biometric Screening Form

Ramp Health has provided our clients a medical form for the purposes of verifying their individual age and gender required 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: _____

You must attach your test results to this form:
*the requirements are for your age and gender specific tests as requested by your PCP.

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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 or 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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