rightway

Wellness Exam Verification Form.

Collection period 04/1/25 - 3/30/26. Forms accepted for physicals dated 04/1/25 - 3/30/26.

To submit your form:

1. Scan the QR code to download the Rightway app, or visit *member.rightwayhealthcare.com*
2. If needed, follow the prompts to activate your Rightway account
3. Select the "Wellness Program" card and follow the prompts to complete all required fields and upload a copy of your completed Wellness Exam Verification Form
4. Click Submit

Participant information

First and last name (please print)	Date of birth (MM/DD/YYYY)	☐ Employee ☐ Spouse

Biometric Results *(Health Care Provider completes the section below. All fields must be completed*)*

Height (in)	Weight (lb)	Body mass index (BMI)	A1c*	Blood pressure
Total cholesterol	**LDL cholesterol**	**HDL cholesterol**	**Triglycerides**	**Fasting glucose***
Tobacco use — last 6 months ☐ Yes ☐ No				

**For fasting glucose and A1c, only one lab value may be acceptable based on the treating physician's recommendation.*

Primary care provider information

Primary care provider name	Primary care provider phone	
Physician name	**Physician signature**	**Date of exam (MM/DD/YYYY)**

Required: Authorization to release protected health information to my / my spouse's employer
(to be signed by the employee/spouse completing this form)

I understand that by submitting this form, Rightway may report to my / my spouse's employer the following information about me: a) name; b) date of birth, c) whether I have verified that I have received my annual physical and d) whether I have met the program compliance. Also, I understand that if Rightway submits this form to my / my spouse's employer that I will receive an email verification from Rightway. I agree that if I do not receive an email verification, it is my responsibility to verify with Rightway that my form has been submitted to my / my spouse's employer. Notwithstanding, I agree that Rightway bears no responsibility, or any legal liability, for its failure to submit this form to my employer.

Signature: _____ Date: _____

Optional: Authorization to release protected health information to my spouse
(If an employee is submitting a form on behalf of their spouse, the spouse must print, sign and date this authorization)

I authorize Rightway to disclose my information, including my protected health information as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), with my spouse who is an employee of Vital MD. My spouse's name is indicated below:

Name of Spouse: _____

Signature of Spouse: _____ Date: _____