2024-2025 Wellness Your Way Program

Healthcare Provider Verification Form

Verified by WELCOAZ Program

Instructions: The qualifying period for completion and submission is **June 1, 2024 to May 31, 2025**. Complete top field of this form and have a healthcare provider complete the bottom portion**.** Submit a copy to the Wellness Council of Arizona. Please *print clearly* and keep a copy of all forms for your own records.

To be filled out by the Participant:

Participant Name		Employee ID #
Gender	**Date of Birth**	**Location**
☐ Male ☐ Female	__ __ / __ __ / __ __ __ __	
Phone Number	**Email**	

Authorization to Release Medical Information

I authorize the release of the following personal information to the Wellness Council of Arizona for the purpose of confirming eligibility to receive my wellness incentive.

Participant Signature **Date**

Your PHI (protected health information) is protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and will be kept secure by the Wellness Council of Arizona. The Wellness Council will notify your employer when you have completed this component satisfactorily. Your employer will not have access to your legally protected health information. The Wellness Council will act as the confidential record keeper of the Health & Wellness Incentive Program on behalf of your employer.

To be filled out by the Physician or Healthcare Provider:

Annual Physical Exam and Lab Work must be completed between June 1, 2024 to May 31, 2025.

Date Participant Underwent their Complete **Physical Exam** with Healthcare Provider	Date Participant Underwent their last Complete **Lab Work** ☐ **Lab Work not required. Healthcare Provider's Initials:_____**
___ ___ / ___ ___ / ___ ___ ___ ___	___ ___ / ___ ___ / ___ ___ ___ ___
Healthcare Provider Printed Name – *REQUIRED*	Healthcare Provider Signature – *REQUIRED*
Phone Number	Date

How to Submit Forms to the Wellness Council of Arizona:

- **Secure Email:** verified@welcoaz.org (preferred method)
- **Mailing Address:** Wellness Council of Arizona
  1670 N. Kolb Rd. Ste. 246, Tucson, AZ 85715
- **Secure Fax Number**: 520-293-3368 (follow up with a call to 520-293-3369 or email to confirm receipt of your fax)

To be completed by Welcoaz Staff:

Date Received	Receipt Type
Date Confirmed	**Date Entered into Tracker**

2024-2025 Wellness Your Way Program

Activity Verification Form

Verified by WELCOAZ Program

Instructions: The qualifying period for submission is **June 1, 2024 to May 31, 2025**. All required components must be submitted by **May 31, 2025** to qualify. Please use the checklist to verify that you have completed the components to receive your **2024-2025 Wellness Your Way Incentive**. Please print clearly on all forms and keep a copy of all forms for your own records.

To be filled out by the Participant:

Participant Name	Employee ID #

Gender	Date of Birth	Location
☐ Male ☐ Female	__ __ / __ __ / __ __ __ __	

Phone Number	Email

Complete 1 of the 5 Activities Below

☐ **Option 1: Non-Tobacco User Affidavit**

I declare that I neither (i) smoke or use tobacco products*, nor (ii) have smoked or used tobacco products at any time during the last three (3) months immediately preceding the date of this affidavit. ** I understand that if I falsely claim the non-tobacco user discount, I will immediately forfeit the wellness incentive. Further, to reapply for the discount in the future, I would be required to submit proof of non-tobacco use as allowed by law to include blood test results.

Likewise, if I become a tobacco user when participating in the wellness incentive program, I must inform Human Resources that I no longer qualify for the discount.

If I fail to do so, I will be subject to the same consequences noted above for making a false claim.

*Smoke or use of tobacco products for purposes of this affidavit means any use of vape, cigarettes, pipes, cigars or chewing tobacco or any other tobacco products regardless of the number of times, frequency or method of use.

I, the applicant, have read the above and understand the penalties that may apply if my statements are false.

Participant Signature: _____ **Date:** _____

☐ **Option 2:** Attend 3 Wellness Webinars, recorded or live.

List the Wellness Webinars you Viewed here:	Date Viewed
1.	
2.	
3.	

☐ **Option 3:** Participate in 3 Health Coaching Sessions with a Wellness Council of Arizona Health Coach.

Health Coach Verification Number:

Date Signed:

☐ **Option 4:** Submit receipts of payment for gym memberships, fitness facility or program, or home use fitness accessories. *Minimum of **$150**, purchased within the last 12 months.

☐ Receipts or Statements included with this form.

☐ **Option 5:** Complete any 2 Wellness Challenges. **To have a challenge qualify for the Wellness Your Way program, you must qualify for the prize drawing within the challenge.*

List the Challenges you Completed Here:
1.
2.

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To be completed by Welcoaz Staff:

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Date Confirmed	**Date Entered into Tracker**