Primary Care Provider and OhioHealth WorkHealth Biometric Screening Instructions

Franklin County Cooperative employees and spouses/domestic partners can earn incentives by completing a Biometric Screening at an onsite event, through a Primary Care Provider, or at any OhioHealth WorkHealth location. All Primary Care Provider and OhioHealth WorkHealth forms must be received by **December 31, 2026**, so please plan appointments accordingly.

Employee and Spouse/Domestic Partner Steps:

1. **AT YOUR PHYSICIAN'S OFFICE:** Schedule an appointment with your Primary Care Provider (PCP). Only appointments on or after **January 1, 2026** will be accepted.

   AT A WORKHEALTH LOCATION: Visit OhioHealth.com/WorkHealth to find a location near you and call (614) 566 – 9675 to schedule an appointment. Only appointments on or after **January 1, 2026** will be accepted.

2. Complete the attached authorization form and all information on the results form above the "Biometric Results – Staff Use Only" line and bring to your appointment. Both forms must be completed, with signature, in order to be processed.

3. Complete your appointment and have the "Biometric Results" section of the results form completed by your PCP or WorkHealth provider. Fully completed forms must be received by OhioHealth Employer Solutions no later than **December 31, 2026.** WorkHealth staff will submit the form on your behalf once they have your results. If you complete your screening with your PCP, it is your responsibility to ensure completed forms are submitted by the deadline. We encourage having your provider provide you with the results so that you can submit them yourself. You or your provider can submit the forms to ThriveOnWellness@OhioHealth.com or fax to (888) 255-0214.

4. Log in to fccThriveOn.com and visit the "Incentives" section to verify that your screening data was received. Forms will be processed within 15 business days of receipt by OhioHealth Employer Solutions.

Provider Steps:

1. Complete the "Biometric Results" section of the results form including height, weight, BMI, blood pressure, lipid, cholesterol, waist measurement and glucose testing.

2. If you are submitting biometric results on behalf of your patient, email the completed authorization and results form to ThriveOnWellness@OhioHealth.com or fax toll free to (888) 255-0214 by **December 31, 2026**.

Please note: Separate reports and lab forms cannot be processed. Results must be submitted on the ThriveOn Biometric Screening Form provided.

WELLNESS SERVICES PROVIDED BY OhioHealth

Authorization for Release of Health Information

Individual's Name (Please Print) _____ Date of Birth _____

Address _____ Phone Number _____

I. Information About the Use or Disclosure

I hereby authorize the use and/or disclosure of individually identifiable health information of the individual named above, as described below. *I understand that this Authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information. As used herein, the term "I," "me" or "my" refers to the Individual, or to the Personal Representative of the Individual, acting on behalf of the Individual or of the Individual's estate.*

Persons/organizations authorized to disclose the information (the "Disclosing Entity"):

OhioHealth and its Employer Services Division

Persons/Organizations authorized to receive and use the information (the "Receiving Entity"):

- ☐ My Insurance Payors
- ☐ My Employer
- ☑ My Employer's Designee or Third Party Vendor
- ☐ My Treating Providers
- ☐ Others: _____

Specific description of information to be used or disclosed:

Unless otherwise specified below, health information gathered by Disclosing Entity on the date this Authorization is signed by me.

☐ Other: _____

Specific purpose of the disclosure:

This disclosure is made at my request.

Expiration:

This Authorization will expire one year from the date set forth below under my signature.

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this Authorization at any time prior to its expiration date by notifying the disclosing entity in writing, but the revocation will not have any effect on any actions the disclosing entity took before it received the revocation.
- A disclosing entity may not condition treatment, payment, enrollment or eligibility for benefits upon whether I sign this Authorization. In addition, the execution of this Authorization is not a condition to enrollment in, or eligibility for benefits under, any health plan, including any group health plan.
- The information that is used or disclosed pursuant to this Authorization may be redisclosed by the receiving entity. In such case, the information will no longer be subject to the protections of the HIPAA Privacy Rule, 45 C.F.R. Parts 160 and 164 (Subparts A and E).

III. Signature of Individual or Individual's Representative (*Form MUST be completed before signing*)

_____ **Signature of Individual or Individual's Personal Representative**	_____ **If Personal Representative, state authority for acting as such (see 45 C.F.R. §164.502(g))**
_____ **(printed name)**	_____ **Date**

A copy of this Authorization shall be considered as effective and valid as the original.

OhioHealth

Franklin County Cooperative Biometric Screening Results Form

To receive credit for your Biometric Screening, please have your healthcare provider complete the Biometric Results section below. Only results between January 1, 2026 and December 31, 2026 will be accepted. All results are confidential: your employer will not receive your individual results. Once completed, submit the form to OhioHealth Employer Solutions via email to ThriveOnWellness@OhioHealth.com or fax toll free (888) 255-0214.

Screening Date: _____

First Name: _____ Last Name: _____

Participant Signature (Required): _____

Employee ID: (Not SS#) _____ Date of birth: _____ Age: _____ Gender (M or F): _____

Employee: ☐ YES ☐ NO Spouse/Domestic Partner ☐ YES ☐ NO

Agency/Location: _____

Phone: _____ Email: _____

Patient Questions:

1. Do you have a primary care physician? ☐ YES ☐ NO
2. Have you seen your primary care physician in the last 3 years? ☐ YES ☐ NO
3. Do you have a **persona**l history (self) for any of the following? **(If yes, check all that apply):** ☐ YES ☐ NO
   ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Stroke ☐ Heart Disease
4. Do you take medication for:
   High Cholesterol ☐ YES ☐ NO Diabetes ☐ YES ☐ NO
   High Blood Pressure ☐ YES ☐ NO **If yes,** have you taken your medication today? ☐ YES ☐ NO
5. Do you use any products with tobacco or nicotine (Cigarettes, e-cigarettes, patches, gum, dip/chew, vapors, etc.)? ☐ YES ☐ NO

BIOMETRIC RESULTS — Staff Use Only

Height: _____ Feet _____ Inches	Weight: _____	Blood: Pressure: #1 ____/____	Blood: Pressure: #2 ____/____	BMI: _____

	Your Levels	Incentive Levels
Blood Pressure	____/____	Both numbers below 130/85
HDL (Good "healthy" Fat)	mg/dl	Female: 50 or above Male: 40 or above
Triglycerides	mg/dl	Below 150
Waist	"	Female: 35" or below Male: 40" or below
Glucose	mg/dl	Fasting: 60 to 100 Nonfasting < 140
Number of Targets Met	_____ /5	

Total Cholesterol: _____

LDL: _____

Cholesterol/ HDL Ratio: _____

A1c: _____

☐ Fasting
☐ Non Fasting

Staff Reviewed: _____

☐ Pregnancy

If you are pregnant or nursing, your cholesterol results may be affected. Please inform health care personnel.

Physician verification: Forms cannot be processed without a full signature, date, printed name and phone number.
Signature agreement: By signing, I verify that the information supplied by myself or my representative here is true and complete. I also understand that any person who knowingly and with intent to injure, defraud, or deceive any healthcare carrier, files a statement of claim, or an application containing any false, incomplete or misleading information will be subject to criminal penalties applicable to state laws.

I certify that I am a primary care provider: ☐Yes ☐No

I certify that I conducted an annual physical for this individual today: ☐Yes ☐No

Physician signature: _____ Date: _____

Physician printed name: _____ Physician phone #: _____

WELLNESS SERVICES PROVIDED BY OhioHealth

OhioHealth Wellness Services
3430 OhioHealth Pkwy | Columbus, OH 43202

Blood Pressure

Blood pressure readings can vary greatly depending on when and where you take them. See your physician if your readings are consistently over 140/90.

Normal: <120/80
Pre-Hypertension: 120–139/80–89
Hypertension: >140/90
Critical Value: >180/110

HDL

HDL is a good fat. **The higher the number the better.** HDL helps prevent the bad fats from building up in the arteries. Exercise also helps increase HDL.

Male: **40 or >**
Female: **50 or >**

Triglycerides

Triglycerides are also a bad fat that can cause plaque to build up in your arteries. **The lower the number the better.** It represents the amount of fat that is in your arteries over the past few days and can increase or decrease frequently. Triglyceride levels may be increased by consuming alcohol, sugar or having a recent meal.

Ideal: <100
Normal: <150
Borderline: 150–199
High: 200–499
Very High: >500

Waist Measurement

Waist measurement indicates a person's risk of health related problems like diabetes and heart disease.

MEN: 40" and over indicates increased risk for weight related health issues.

WOMEN: 35" and over indicates increased risk for weight related health issues.

Cholesterol/HDL Ratio

This measure is calculated to identify the balance of good fat to bad fat. It should be less than 5.1. It shows there is a protective action even when the "lousy" LDL cholesterol is outside of normal limits.

Normal: <5.1
Ideal: <3.5

Glucose (fasting)

This measures the amount of sugar in your blood. It is used to help diagnose diabetes and monitor those who have diabetes.

FASTING RANGES
Normal: 60–100
Borderline/Pre-diabetes: 101–125
High/Diabetes: 126 or >

***NON-FASTING RANGES**
Normal: <140
Borderline/Pre-diabetes: 141–200
Diabetes: 200+
Critical Value: 400 or >

Cholesterol

Cholesterol is a fat-like substance that clogs arteries. A cholesterol test checks the levels of your total blood cholesterol, LDL, HDL, and triglycerides.

Ideal: <200
Borderline High: 200–239
High: >240

BMI

Body Mass Index (BMI) is a measurement of your weight relative to your height. It is a screening tool used to identify possible weight related problems.

Underweight: Below 18.5
Normal: 18.5–24.9
Overweight: 25.0–29.9
Obese: 30.0 or >

LDL

LDL is a bad fat that can cause plaque to build up in your arteries. **The lower the number the better**. It represents the amount of bad fat that is in your arteries over the past few months and years and takes time to increase or decrease. Reducing the amount of saturated fat in your diet can improve your LDL. Examples of saturated fats include meat, whole milk, cream, ice cream, butter, cheese, lard and bacon.

Excellent: <70
Ideal: <100
Normal: 100–129
Borderline: 130–159
High: 160–189
Very High: 190 or >

A1C

The A1C test is used to detect Type 2 diabetes and prediabetes. The tests provides information about a person's average blood sugar level over the past 3 months. The higher the percentage, the higher a person's blood sugar level has been. Testing enables health care providers to identify and treat diabetes before complications occur and to find and treat prediabetes which can delay or prevent Type 2 diabetes from developing.

Normal: below 5.7%
Pre-diabetes: 5.7%–6.4%
Diabetes: 6.5% or >

Risk Factors

Health screenings are done to identify individuals with one or more risk factors for health problems.

Risk factors you can change or control are: smoking, high cholesterol, high blood pressure, diabetes, diet, weight, and exercise.

Risk factors you cannot change or control are: age, gender, race, previous stroke, family history of stroke or heart disease.

It is important to discuss these results and any necessary follow up with your primary care physician.

To find a primary care physician, please call an UHC Customer Advocate at **1 (877) 440-5983** or visit **MyUHC.com**.

You may also contact your Franklin County Cooperative Health Engagement Nurses at **(614) 525-6773**.

OhioHealth

