

2021 Health Appraisal

Biometric Verification Submission Instructions



All employees, retirees and spouses are welcome to participate.

1. Log Into Your Wellness Portal

Access the portal from your computer, tablet or smartphone.

Tip: To access the wellness portal from the Froedtert & MCW app, follow the log in steps on page 2 of your Health Appraisal Instructions.



Portal URL: www.workforcehealth.org/Hartford

Log into the portal using your previous username and password to complete the health questionnaire, submit your biometric verification form and consent, and to view additional wellness resources.

To register if you are a new user or to reset your password or retrieve your username, use company code: **0063** and your User ID: which is your **8-digit UMR Member ID** (Spouse: Use employee's 8-digit UMR Member ID plus SP (ex. 12345678SP).

2. Complete the Health Questionnaire



Complete the secure online health questionnaire on the wellness portal. It takes about 15 minutes to complete and will generate a report providing a snapshot of your current health and future disease risk based on your responses.

Complete the questionnaire prior to submitting your information the wellness portal.

3. Submit Your Completed Forms



Using your computer, smartphone or tablet, log into the wellness portal. On the home page, locate the "Biometric Verification Submission" box and click "Submit your Proof of Participation" link. Upload your completed Biometric Verification Form and if you chose Option 2, your lab work obtained from your Primary Care Provider.

Lab work needs to be completed by your Primary Care Provider between January 1 – July 30, 2021

**Submission Deadline:
August 4, 2021**

Note: Forms will be processed within 10 business days

Questions?

Contact Workforce Health at 414-777-3596
Monday-Friday, 7:30 a.m.-4:30 p.m.



Workforce Health

Biometric Verification Form

City of Hartford 2021 Health Appraisal

Biometrics must be completed between

January 1, 2021 and July 30, 2021

This form must be submitted to Workforce Health by

August 4, 2021.

It is your responsibility to ensure **ALL** fields on this Biometric Verification Form are complete in order to process your paperwork.

For office use	ID# 0063
CRN: _____	
Last Name	First Name
DOB: _____	Gender: M / F

Participant Full Name: _____ Date of Birth: _____

Email: _____ Phone: _____

***Option 1:** Have your health care provider (or clinic staff) complete fields below and sign.*

Option 2: Attach a comprehensive biometric/lab report(s) with values dated *between January 1, 2021 and July 30, 2021* and complete fields below.

ALL fields are required:

Date of Lab Work:		Medical Facility Name:	
Height (inches):	Weight (lbs):	Waist Circumference (inches): (to be measured around midsection at naval)	
Blood Pressure:	Cholesterol:	HDL:	Non-HDL:
LDL:	Triglycerides:	Glucose value:	
		Fasting <input type="checkbox"/>	Non-fasting <input type="checkbox"/>
Do you use any products that contain tobacco/nicotine?		Yes <input type="checkbox"/>	No <input type="checkbox"/>

Provider Name: (Please print) _____

***Provider/Clinic Staff Signature:** _____

When form is complete, refer the [2021 Health Appraisal Biometric Verification Instructions](#) page.

Contact Workforce Health with any questions at 414-777-5890.

Monday – Friday: 7:30 a.m. - 4:30 p.m.

Note: The medical information in this attachment has been released according to Wisconsin State Statutes 146.81-.83, 250, 252, 51.30 and Federal Law 42 CFR164. Confidentiality of this information is protected. The recipient of this information is prohibited from re-disclosing the information to any other party under these statutes. The information in this facsimile message is intended for the personal and confidential uses of the designated recipients named above. The information is privileged and confidential. If the reader of this message is not the intended recipient, you are hereby notified that you have received this document in error and that any review, distribution, or copying of this information is strictly prohibited. If you have received this communication in error, please notify the sender immediately and destroy the documents you received.



Workforce Health