Atlantic Packaging Wellness Incentive Program
2025 Annual Physical with Labs/Biometric Screening Form

NOTICE TO PATIENT
Please fill out the top portion of this form and take it to your medical provider when you complete your annual physical with labs/biometric screening. This activity must occur between September 1, 2024 and August 31, 2025 to count towards the Atlantic Packaging Wellness Incentive Program activities. Once completed by your provider, it is YOUR responsibility to return this form to Marathon Health at the contact information below. BY COMPLETING THIS FORM AND SUBMITTING IT TO MARATHON HEALTH, YOU CONSENT TO THE DISCLOSURE BY MARATHON HEALTH TO ATLANTIC PACKAGING THAT YOU HAVE COMPLETED THE ACTIVITIES DESCRIBED BELOW. You may revoke your consent to this disclosure at any time by sending us a notice in writing. Your revocation will not apply to information already disclosed by Marathon Health pursuant to this verification form.

TODAY'S DATE

PATIENT NAME (Please Print Clearly)

PATIENT DATE OF BIRTH

NOTICE TO PROVIDER
Your patient has an opportunity to complete an annual physical with labs/biometric screening as a part of their employer or group health plan's wellness incentive program. Please complete the section below to verify that you have provided services to this patient.

QUALIFYING PROGRAM ACTIVITY	DATE OF EXAM	PROVIDER INITIALS
ANNUAL PHYSICAL		
ANNUAL HEALTH SCREENING CRITERIA	**DATE TEST ADMINISTERED**	**RESULTS**
BODY MASS INDEX (BMI)		Height _____ in. / Weight _____ lbs
WAIST CIRCUMFERENCE		Value: _____in.
BLOOD PRESSURE		Value: _____ / _____ mmHg
TOTAL CHOLESTEROL		Value: _____mg/ dL
HDL CHOLESTEROL		Value: _____mg/dL
TRIGLYCERIDES		Value: _____mg/dL
LDL CHOLESTEROL		Value: _____mg/dL
HEMOGLOBIN A1C OR GLUCOSE		Value: _____% or _____ mg/dL

Submission Instructions:
Forms due to Marathon Health no later than August 31, 2025.

FAX OR EMAIL YOUR COMPLETED FORM TO THE FAX NUMBER OR EMAIL ADDRESS BELOW.

Marathon Health
F: 802.419.9688
E: wellness@marathon-health.com

Marathon Health

Atlantic Packaging Wellness Incentive Program
2025 Provider Verification Form

NOTICE TO PATIENT
Please fill out the top portion of this form and take it to your medical provider when you complete your preventive screening/exam or qualifying wellness activity. This activity must occur between September 1, 2024 and August 31, 2025 to count towards the Atlantic Packaging Wellness Incentive Program activities. Once completed by your provider, it is YOUR responsibility to return this form to Marathon Health at the contact information below. BY COMPLETING THIS FORM AND SUBMITTING IT TO MARATHON HEALTH, YOU CONSENT TO THE DISCLOSURE BY MARATHON HEALTH TO ATLANTIC PACKAGING THAT YOU HAVE COMPLETED THE ACTIVITIES DESCRIBED BELOW. You may revoke your consent to this disclosure at any time by sending us a notice in writing. Your revocation will not apply to information already disclosed by Marathon Health pursuant to this verification form.

TODAY'S DATE

PATIENT NAME (Please Print Clearly)

PATIENT DATE OF BIRTH

NOTICE TO PROVIDER
Your patient has an opportunity to complete preventive screenings/exams or other wellness activities as a part of their employer or group health plan's wellness incentive program. Please complete the section below to verify that you have provided services to this patient.

2025 Incentive Program Qualifying Activities		
Program Activity	Activity Date	Provider Signature or Stamp
Colonoscopy		
Dental Exam/Cleaning		
Mammogram		
Prostate Exam		
Skin Check		
Vision (Eye) Exam		
Well-Woman Exam		

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