

Annual Wellness Screening Form

Participant Name: _____
First Name Last Name

Check One: Employee Spouse

BCBST ID Number:

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PROVIDER COMPLETES THIS SECTION

Date of Wellness Exam: MM/DD/YYYY

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I certify that the member named above has completed an annual wellness exam.
 (check box)

Provider Name (Printed):	
Provider Signature:	
Provider Office Phone Number:	
Date:	

❖ Please Return Completed Form to ONE of the following options:

- Mail to: Holston Conference Office of Pensions & Health Benefits, P.O. Box 850, Alcoa, TN 37701-0850
- Fax To: 865-690-3162
- Scan and Email to: kenluton@holston.org