MAYFIELD CITY SCHOOL DISTRICT 2017-18 BIOMETRICS CERTIFICATION

PHYSICIAN'S CERTIFICATION OF RESULTS OR TREATMENT

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME		MIDDLE INITIAL
ADDRESS	CITY		ST/ZIP
EMPLOYEE ID #	COVERAGE TYPE	HEIGHT	WEIGHT

PHYSICIAN CERTIFICATION NOTICE

This form must be completed and certified beginning May 22, 2017 and submitted by October 31, 2017 to be eligible for 2018 deductible credit consideration.

PHYSICIAN CERTIFIED RESULTS, CONTINUOUS TREATMENT OR MEDICAL CONDITION APPEAL

This form is designed to provide the opportunity to use your personal physician's certification for the BMI, cholesterol and/or blood pressure categories. In addition, if you are actively being treated for any of these conditions, or have a pre-existing medical condition which prevents you from achieving the target scores, your healthcare professional may certify this below.

PHYSICIAN'S NAME	PHYSICIAN PHONE NUMBER	PATIENT SINCE
ADDRESS/SUITE	CITY	ST/ZIP
PATIENT EXAMINATION DATE	PATIENT HEIGHT	PATIENT WEIGHT

1 ANNUAL PHYSICAL: HAS THE PATIENT HAD AN ANNUAL PHYSICAL INCLUDE LAB WORK (CBC, CMP, LIPID, GLOCOSE) IN THE LAST 12 MONTHS? (Y) (N)

2 TOBACCO USER: IS THE PATIENT CURRENTLY USING OR HAS THE PATIENT REPORTED USING TOBACCO RELATED PRODUCTS WITHIN THE LAST12-MONTHS. (Y) (N)

3 BLOOD PRESSURE: **SYSTOLIC**_____ **DIASTOLIC** _____

IS THE PATIENT CURRENTLY BEING TREATED FOR HIGH BLOOD PRESSURE? (Y) (N)

IS THE PATIENT COMPLIANT WITH CURRENT TREATMENT FOR HIGH BLOOD PRESSURE? (Y) (N)

4 CHOLESTEROL: **HDL**_____ **LDL**_____ **TOTAL** _____

IS THE PATIENT CURRENTLY BEING TREATED FOR HIGH CHOLESTEROL? (Y) (N)

IS THE PATIENT COMPLIANT WITH CURRENT TREATMENT FOR HIGH CHOLERSTEROL? (Y) (N)

5 GLUCOSE/BLOOD SUGAR: _____

6 ADDITIONAL INFO: ARE THERE ADDITIONAL CONSIDERATIONS OR CONDITIONS WHICH PRECLUDE THIS PATIENT FROM IMPROVING HER/HIS BMI, BLOOD PRESSURE OR CHOLESTEROL? PLEASE EXPLAIN.

PHYSICIAN SIGNATURE	DATE

IMPORTANT EMPLOYEE INFORMATION RELEASE

By signing this form, I certify that I am voluntarily providing this information to appeal or supplement eligibility for deductible credits that are available to you on a voluntary basis. I understand that information provided on this form is considered Protected Health Information (PHI) and thus protected under the provisions of HIPAA. I understand that by submitting this form, I authorize my healthcare professional, GBS, Medical Mutual of Ohio and the Mayfield City School District Employee Benefit Program to document this information specifically for the purpose of deductible credits and application.

EMPLOYEE SIGNATURE	DATE

FORMS MUST BE SUBMITTED BY OCTOBER 31, 2017 TO QUALIFY FOR 2018 DEDUCTIBLE CREDIT.

GALLAGHER BENEFIT SERVICES - MISSY SCIRIA -234-380-4470 - SUBMIT VIA FAX TO 330-315-5125-E-MAIL missy_sciria@ajg.com