MAYFIELD CITY SCHOOL DISTRICT 2018-19 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	WEIGHT

PHYSICIAN CERTIFICATION NOTICE

This form must be completed and certified beginning June 1, 2018 and submitted by October 31, 2018 to be eligible for 2019 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 INCLUDING 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 LAST 12-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 CHOLESTEROL? Y N

5 GLUCOSE/BLOOD SUGAR: ______ A1C ______

IS THE PATIENT CURRENTLY BEING TREATED FOR HIGH BLOOD SUGAR? Y N

IS THE PATIENT COMPLIANT WITH CURRENT TREATMENT FOR HIGH BLOOD SUGAR? Y N

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

COMPLETED FORMS MUST BE SUBMITTED BY OCTOBER 31, 2018 TO QUALIFY FOR 2019 DEDUCTIBLE CREDIT.

If you have questions, please call Pat Martinson, Gallagher Benefit Services at (234) 380-4468

SUBMIT VIA FAX TO (330) 294-5626 OR E-MAIL GBS.MayfieldSchools@ajg.com