

## 2020 City of Montgomery Wellness Program Private Physician Form

**Instructions:** This form is used to comply with the City's Wellness Program by completing your Annual Health Assessment (AHA) for January 1, 2020 – September 30, 2020. If you choose not to participate in the wellness screening at CareHere, you may submit your screening results through your private physician using this form. You must complete Section 1 of this form and your provider is to complete Section 2. In order to be in compliance for your AHA, this form should be returned to the Risk Management Benefits Division Office 108 in City Hall by September 30<sup>th</sup>. If you do not have City insurance, you do not have to complete this form.

**This form does not have to be completed if you have your screening completed at CareHere.**

### Section 1: PATIENT INFORMATION (To be completed by employee)

<b>Member Name (Please Print)</b>	<b>Screening Date</b> (mm/dd/yyyy)	<b>Male</b> _____ <b>Female</b> _____ <b>Age</b> _____
<b>Blue Cross Blue Shield Contract #</b>	<b>Date of Birth</b> (mm/dd/yyyy)	<b>Day Time Phone Number</b>

**The member will be responsible for any applicable charges for any lab work ordered by the provider.**

I hereby authorize the release of medical information listed in Section 2 to the Risk Management Benefits Office of the City of Montgomery. I understand that this information will be used for statistical purposes only and **will not** be released to any other person or persons. I also understand that this information **will not** be used to deny health insurance coverage to me as an employee of the City of Montgomery.

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**IT IS YOUR RESPONSIBILITY TO RETURN THIS COMPLETED FORM TO THE RISK MANAGEMENT BENEFITS DIVISION BY SEPTEMBER 30<sup>th</sup>. NO EXCEPTIONS!**

### Section 2: BIOMETRICS (To be completed by provider)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Height        | <input type="checkbox"/> Total Cholesterol     |
| <input type="checkbox"/> Weight         | <input type="checkbox"/> Blood Glucose | <input type="checkbox"/> Body Mass Index (BMI) |

The above mentioned individual was evaluated in my office on \_\_\_\_\_ and was counseled regarding his/her health risk factor(s).

**Provider Name: (Please Print)** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_

Please fax signed form to 334-625-4410 or return to Office 108 at 103 North Perry Street. For additional assistance please contact Angela Berry at 334-625-2510 or Faye Gamble at 334-625-2692.