



Certification of Annual Wellness Exam

Your patient is a participant in the Manatt's, Inc., and Affiliates Wellbeing Program. Employees and Spouses receive a premium incentive for participating in health and wellbeing activities. To receive the incentive in 2019, participants must receive an annual preventative exam between **January 1, 2019 and November 30, 2019**.

SECTION I: TO BE COMPLETED BY EMPLOYEE OR SPOUSE (PLEASE PRINT)

Employee Name: _____ Employee Number: _____

Patient Name: _____

Primary Phone Number: () _____

I certify that the below is accurate to my knowledge and that if I knowingly falsify any documents relating to the wellness program, I will receive punishment, including possible termination. I understand it is solely my responsibility to follow up with my personal physician for results outside of the normal range or if I have any questions or concerns regarding my health.

Signature: _____ Date: _____

*By signing above, I agree and understand that I may have out-of-pocket expenses associated with the screening provided by my provider.

SECTION II: TO BE COMPLETED BY YOUR PHYSICIAN.

Physician Instructions: For the premium incentive to be met, only the items listed below need to be completed. We do encourage any other preventative care be recommended by you for our employees and/or spouses, as necessary.

Please use DX Code "Z00.00 Encounter for general adult medical examination without abnormal findings" or "Z00.01 Encounter for general adult medical examination with abnormal findings".

It is not necessary for employees and/or spouses on our health plan to have to wait 12 months between annual preventative exams, it will still be paid at 100%.

Our medical plan also covers CDL/DOT physicals at 100%. Please submit these claims directly to UMR with the diagnosis code "Z02.89 Encounter for other administrative examinations."

Return completed form either by secure fax at 563.659.3393 or email to wellbeing@wendlingquarries.com

Date of Physical Examination: _____

Please check (✓) the following items as completed. **Do not include actual test results.**

- | | |
|---|---|
| <input type="checkbox"/> Annual Preventative Exam | <input type="checkbox"/> Triglycerides |
| <input type="checkbox"/> Total Cholesterol | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> LDL Level | <input type="checkbox"/> Glucose Level |
| <input type="checkbox"/> HDL Level | <input type="checkbox"/> A1C Level (for diabetics only) |

I certify that I have performed these items on the patient listed above. I am working with this patient on any results returned that are considered to not be within normal range.

Physician Signature: _____

Physician Name (please print): _____

Physician Address: _____

Physician Phone Number: _____