MAYFIELD CITY SCHOOL DISTRICT 2023-24 BIOMETRICS CERTIFICATION

PROVIDER'S CERTIFICATION OF RESULTS OR TREATMENT

**Please note that incomplete and/or illegible forms will not be processed. Please review for accuracy and legibility prior to submitting form.*

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	EMPLOYEE ID #

ADDRESS, APT #, CITY, STATE, ZIP CODE	EMAIL ADDRESS

PROVIDER CERTIFICATION NOTICE

This form must be completed and certified beginning June 1, 2023 and submitted by October 31, 2023 to be eligible for 2024 deductible credit consideration.

PROVIDER CERTIFIED RESULTS, CONTINUOUS TREATMENT OR MEDICAL CONDITION APPEAL

Provide your personal provider's certification for the blood pressure, cholesterol and BMI categories below. 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.*

PROVIDER NAME	PROVIDER PHONE NUMBER
PATIENT EXAMINATION DATE	**FASTING?** Y ☐ N ☐
PATIENT HEIGHT	**PATIENT WEIGHT**

1) ANNUAL PHYSICAL:	HAS THE PATIENT HAD AN ANNUAL PHYSICAL INCLUDING LAB WORK (CBC, CMP, LIPID, GLUCOSE) IN THE LAST 12 MONTHS?	**Y ☐ N☐**
2) TOBACCO USER:	IS THE PATIENT CURRENTLY USING OR HAS THE PATIENT USED TOBACCO-RELATED PRODUCTS IN THE LAST 12 MONTHS?	**Y ☐ N☐**
3) BLOOD PRESSURE (Goal for incentive: ≤ 140/90)**:**	**SYSTOLIC _____ DIASTOLIC _____** *IF OUTSIDE OF THE STATED PARAMETERS, I CERTIFY THAT MY PATIENT IS BEING TREATED FOR HIGH BLOOD PRESSURE	**Y ☐ N☐**
4) TOTAL CHOLESTEROL (Goal for incentive: ≤ 240)**:**	**HDL_____ LDL _____ TOTAL _____** *IF OUTSIDE OF THE STATED PARAMETERS, I CERTIFY THAT MY PATIENT IS BEING TREATED FOR HIGH CHOLESTEROL	**Y ☐ N☐**
5) BMI (Goal for incentive: ≤ 30)**:**	**BMI _____**	
6) GLUCOSE (Goal for incentive: ≤ 100 or ≤ 6% a1c)**:**	**GLUCOSE_____ a1c _____** *IF OUTSIDE OF THE STATED PARAMETERS, I CERTIFY THAT MY PATIENT IS BEING TREATED FOR HIGH GLUCOSE	**Y ☐ N☐**
7) 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. _____ _____	

PROVIDER SIGNATURE	DATE

IMPORTANT EMPLOYEE INFORMATION RELEASE

I certify that I am voluntarily providing this information to appeal or supplement eligibility for deductible credits that are available on a voluntary basis. I understand that information provided is considered Protected Health Information (PHI) and protected under HIPAA. I authorize release of my results to OsWell *powered by Spark360*. I understand that per the Notice of Privacy Practices, my PHI may be disclosed to Oswald Companies and OsWell *powered by Spark360*, 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. Although all precautions are taken to avoid breach, I understand that because a fax is a physical document, there is potential risk for a security breach and my PHI could be compromised.

EMPLOYEE SIGNATURE	DATE

EMPLOYEE IS RESPONSIBLE FOR SUBMITTING COMPLETED FORMS BY OCTOBER 31, 2023 TO QUALIFY FOR 2024 DEDUCTIBLE CREDIT.

UPON FORM COMPLETION:

Employee should submit the form via online upload within the employee benefit website. The link to submit is located on the WELLBEING PAGE within the Employee Benefit Website: Mywildcatbenefits.com. If you have any questions, please email wildcatbenefits@oswaldcompanies.com