THE CITY OF FRANKFORT

Wellness Screening Provider Care Waiver Form

PARTICIPANT NAME:_____

DATE OF BIRTH:_____

LAST 4 NUMBERS OF SOCIAL SECURITY NUMBER: _____

(*Please print all information legibly*)

SCREENING PARTICPANT DIRECTIONS

Use this form, **if at the time of your City of Frankfort wellness screening**, one or more of the following occurred:

- your results were outside of the incentive standards (results can be found on your "Know Your Numbers Form")
- you are currently participating in a Tobacco Cessation program
- you are currently pregnant or one-year postpartum

Please have your physician complete and sign this form indicating which of the following conditions you are currently being monitored/treated for. **This form is not necessary if your results were within the incentive standards.**

Physician use only

Please indicate which of the following you are currently providing to the patient by checking the corresponding box(es) and signing below. It is not necessary to enter any values. **Please print and sign legibly.**

☐ monitored or treated for elevated Cholesterol

☐ monitored or treated for elevated Blood Pressure

☐ monitored or treated for elevated Glucose

☐ currently participating in Tobacco Cessation Program

☐ currently Pregnant or one-year postpartum

Provider Signature:_____

Provider Printed Name and Title:_____

Phone number _____Date:_____

This form must be faxed ***from the provider's office and include office cover sheet*** *to 317-968-1039, Attn: IU Health Business Solutions*

Form must be received by our office by October 31, 2020