Certification of Annual Preventative Exam

Your patient is a participant in the Manatt's Family of Businesses Wellbeing Program. Employees can receive incentives for participating in health and wellbeing activities. To receive an incentive in 2021, participants must receive an annual preventative exam between **January 1 and November 30, 2021** and complete at least two additional wellbeing objectives.

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 wellbeing 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*: Only the items listed below need to be completed. We do encourage any other preventative care be recommended by you 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 wait 12 months between annual preventative exams. Exams less than 12 months apart will 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 641.522.5090 or email to: **wellbeing@manatts.com**

Date of Physical Examination: _____

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

( ) Annual Preventative Exam
( ) Total Cholesterol
( ) LDL Level
( ) HDL Level
( ) Triglycerides
( ) Blood Pressure
( ) Glucose Level
( ) 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: _____