Doctor Certification Form

EngagementHealth®
IMPROVING WELLNESS™

Dear EngagementHealth Member:

Please have your health care provider complete this form and fax it to the number below.

Note: If you would like to give your Health Care Provider permission to speak to EngagementHealth about your specific results, please sign below to authorize the release of this information.

*Patient Print Name:*_____ *Date:*_____

Patient Signature: _____

Dear Health Care Provider:

Your patient is a member of a company-sponsored wellness program from EngagementHealth. In order for your patient to receive the 'Healthy Rewards' exemption from the program they must meet the following measures:

- **BMI ≤ 25**
- **Blood pressure ≤ 120/80**
- **Total Cholesterol/HDL ratio ≤ 5**
- **Tobacco Free**

An alternative to achieving all the measures is to participate in a participation-based wellness program for the duration of the year. An individual can select from one of the following program options: Steps (exercise), Nutrition, Stress, Tobacco, High Blood Pressure, High Cholesterol, and Diabetes. All programs include weekly reporting of some health information and at least one call with a health coach.

Your patient did not pass one or more of the above metrics, however, feels that he/she should have earned the 'Healthy Rewards' exemption regardless of the program biometric requirements. The individual can qualify for the 'Healthy Rewards' exemption if her/his Health Care Provider recommends a waiver from the wellness program.

You may want to recommend waiving your patient if they are in excellent health but failed to pass one or more of the above measures due to, for example:

☐ **BMI** – high muscle mass; ☐ **Blood Pressure** – genetic predisposition; ☐ **Cholesterol** - genetic predisposition, age.

☐ I agree my patient should be waived from the wellness program

☐ No, I think my patient would benefit from participating in a wellness program.

If you would like to contact EngagementHealth about your patient's specific results, please contact us at: 888-364-4584 ONLY if your patient has signed the release at the top of this form.

Patient Name:		Date:	/ /

Signed (MD/NP/PA):_____

Print Name:_____

Address:_____

Phone:_____

Please complete and FAX this form to (312) 207-1863.