Western Pennsylvania Schools Health Care Consortium

Physician Certification Form and Biometric Screening Certification Form - Due 4/30/20

Plan Year starting July 1, 2020

Employee / Spouse Complete This Section

Please complete a separate form for employee and spouse

Patient's Name: _____

Employee Name: _____

School District Name: _____

The two (2) criteria of the 2020 WPSHCC Wellness Program are the following:

STEP 1: **Certification of completion of an Annual Preventive Care Examination**

(Required for both Employee and Spouse, if enrolled in the Health Care Plan)

a. Have your Physician complete ***Step 1: Preventive Exam*** section of this form and submit it to the Business Office to satisfy this requirement**; AND**,

STEP 2: **Receive a Comprehensive Biometric Screening, inclusive of**:

(Required for both Employee and Spouse, if enrolled in the Health Care Plan)

a. LDL, HDL and Total Cholesterol;
b. Triglycerides;
c. Glucose; and
d. Blood Pressure

Two Options to Complete Biometric Screening:

a. Complete on your own and have the physician certify completion in the ***Step 2: Biometric Screening*** section of this form. Submit it to the Business Office to satisfy this requirement**; OR,**

b. Participate in the district's on-site biometric screening held during the 2019/2020 school year *(dates to be determined)*. Districts will receive a report indicating who completed the on-site screening and you will be given credit for completion *(no results reported to district, just completion)*. **Physician does NOT need to certify completion of the on-site biometric screening**. You may complete both option a and b, if you choose.

Step 1: Health Care Provider Complete This Section for Preventive Exam

We ask that you certify that your patient, listed above, has received their Annual Preventive Examination during the period of **May 1, 2019 through April 30, 2020.**

By signing and dating below, you are certifying that the above named patient has received a preventive exam between the above referenced date range.

Health Care Provider's Name (printed or typed): _____

Health Care Provider's Signature: _____ Date: _____

Date of Preventive Exam: _____

Please contact your District's Business Office with any questions regarding the Physician Certification Form and Preventive Biometric Screening.

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Step 2: Health Care Provider Complete This Section for Biometric Screening (if applicable)

We ask that you certify that your patient, listed above, has received their Preventive Biometric Screening during the period of **May 1, 2019 through April 30, 2020** as defined in STEP 2 on the first page of this form.

By signing and dating below, you are certifying that the above named patient has received a Preventive Biometric Screening between the above referenced date range.

Health Care Provider's Name (printed or typed): _____

Health Care Provider's Signature: _____ Date: _____

Date Biometric Screening Performed: _____

- *Preventive Biometric Screenings are covered at 100% when coded as a Preventive Service.* ***UPMC covers once per plan year (July 1-June 30)*** *and* ***Highmark covers once per calendar year (January 1 – December 31st)****. You should discuss coverage of Biometric Screenings as a Preventive Service with your Physician's office prior to the service or call your Insurance Administrator at the number on the back of your Identification Card.*

District Employee / Spouse – Please submit this completed form to your District's Business Office by April 30, 2020 to receive Wellness Credit.

Please contact your District's Business Office with any questions regarding the Physician Certification Form and Preventive Biometric Screening.