ATSG

2021 Outside Provider Annual Physical Verification Form

Dear ATSG employees:
Please use this form for your annual physical and biometric screen. Please complete the section between the blue lines and then review this document prior to your appointment. During the visit with your health care provider, please discuss preventive care and be sure to inquire about additional recommended screenings. After your visit, submit this form to Marathon Health to be eligible for incentives by completing and obtaining your annual physical and biometric screen. Forms can be submitted to Marathon Health via fax, email, or mail. Contact information is located at the bottom of the page. **Your annual physical must be completed and submitted between January 1, 2021 and November 30, 2021.**

Please note, Marathon Health may use and disclose your personally identifiable information obtained on this form, including, but not limited to, your name, date of birth, and screening results (your "Personal Information") to provide health management services to you. These services include using the Personal Information to inform you of relevant health related and health education programs offered by Marathon Health.

Patient Name (please print):_____Patient Date of Birth: _____

Dear Health Care Provider:
Your patient is participating in an employer- sponsored wellness program that provides financial incentives. To earn the incentives, your patient will need to obtain an Annual Physical. Upon completion, please return this form to your patient or send directly to Marathon Health, via the contact information listed at the bottom of page. Thank you for your assistance. ***Instructions for provider use: Hemoglobin A1c (CPT 83036, 83037) and fasting lipid panel (CPT 80061) or non-fasting lipid panel (CPT 83718 or 82465).**

Date of annual physical exam:_____/_____/_____*(This date must be between January 1, 2021 and November 30, 2021)*

SECTION I: BIOMETRIC RESULTS – This section must be completed in its entirety.

Screening Test	Result
BMI	BMI:_____ (optional value, MH will calculate based on Ht and Wt data)
Height Weight Waist Circumference	Height:_____in. Weight:_____ lbs Waist Circumference: _____ in. (possible alternative metric, if BMI >25.0)
Blood Pressure	_____ /_____mm HG
Hemoglobin A1c	_____mg/dL
Total Cholesterol HDL Cholesterol	_____mg/dL _____mg/DL
Tobacco	Tobacco use indicated for the last 90 days: Yes or No (please circle one)

☐ I affirm that the information provided is true and correct to the best of my knowledge.

Health Care Provider Name (please print):_____Phone: _____

Health Care Provider Signature:_____Date:_____

Please fax, mail, or email this form to Marathon Health, using the information below. You must submit your biometric results and your annual physical no later than November 30, 2021.