Doctor Verification Form*
MCSIG Health Screening Alternate Activity

***You do not need this form if you completed a MCSIG health screening at a worksite.**

Dear Healthcare Provider;

MCSIG and PACE health plan members can earn a yearly cash reward ($100 - $250) by completing approved health actions. The member must complete the following health actions by June 1, 2021 to be eligible.

1. Receive **Health Screening (lab results)** from a physician or at a MCSIG onsite health screening.
2. Complete an online **Personal Health Assessment** survey at www.wellsteps.com/mcsig.
3. Complete a 5-10 week **behavior change campaign** offered by MCSIG Wellness.

Section 1: MCSIG or PACE Member

Name _____ Date of birth_____
(Please print clearly)

E-mail address_____ phone (____) _____

By signing below, I give my healthcare provider permission to answer the questions listed below.

X_____ Date _____
Signature of Employee/Plan member

Section 2: Healthcare Provider

The patient named above has received the following required tests. Please record the results in the boxes.

Height (inches):	Weight (lbs.):	BMI or Waist Circumference:
Total Cholesterol:	HDL:	TC/HDL Ratio:
Glucose (fasting):	Or Glucose (non-fasting):	Blood Pressure:

All information collected by MCSIG Wellness, a confidential third party, meets and complies with HIPAA laws.

The Patient named above is being treated, or is under my care for:

High Cholesterol ◯ Blood Pressure ◯ Blood Sugar ◯ Nutrition/Exercise/Mindfulness ◯

X_____ Date _____ Phone _____
Signature of Physician/Licensed Medical Provider

Healthcare Provider's Name (please print): _____

MCSIG member submit this completed form to WellSteps or MCSIG no later than June 1, 2021!

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