



# Healthy Tomorrows Reporting Form Plan Year 2018

PEIA ID # (from medical ID card)	7	7	0	0						
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Policyholder Name: \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**For Plan Year 2018** (July 1, 2017 – June 30, 2018), the PEIA Finance Board has authorized a deductible increase of \$500 for any PEIA PPB Plan policyholder who does not pick a Primary Care Provider (PCP) and report the following biometric data before the end of Open Enrollment in 2017 (mid-May 2017), and have the numbers within the acceptable ranges. All active employees and non-Medicare retired policyholders in any PEIA PPB Plan must report this data. Health Plan members do not have to comply.

### Instructions for Provider

1. Please report the biometric values below.
2. Complete the contact information, including signature and date.
3. Return completed form to patient.

**All fields are REQUIRED. Any missing data will cause the form to be rejected.**

**Blood Pressure:** Systolic >140  ≤140

Diastolic >90  ≤90

**Total Cholesterol:** >245  ≤245

**Glucose:** >125  ≤125

**Waist Circumference (in inches):** Male >40  ≤40

Female >35  ≤35

### Provider Contact

Name of Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

### Medical Certification

I, \_\_\_\_\_, certify that the patient indicated above has received the measurements indicated on this form.

\_\_\_\_\_  
(Signature of Provider or Representative)

\_\_\_\_\_  
(Date of Service)

### Medical Exception Certification (for Plan Year 2018, if applicable)

I, \_\_\_\_\_, certify that, in my best medical judgement it is unreasonably difficult due to a medical condition for the patient to meet these measurements.

\_\_\_\_\_  
(Signature of Provider or Authorized Representative)

\_\_\_\_\_  
(Date of Service)

Please return this form to: **PEIA Healthy Tomorrows, P.O. Box 40360, Charleston, WV 25364**