WORKING Well
Ball State University

Wellness Program Annual Physical Exam Verification Form

Employee Information (this section to be completed by employee)

Patients Full Legal Name (printed):_____

Date of Birth: _____/_____/_____

☐ Ball State University Employee
Employee ID#_____

☐ Spouse
BSU Spouse Name_____

Dear Health Care Provider:

Your patient is involved in an employer-sponsored wellness program that provides financial incentives for the completion of an annual physical examination. Completion and submission of this form is required for your patient to earn these incentives. Thank you for your assistance.

Physician Certification (this section to be completed by physician office)

By completing and signing below, we certify that we have provided an annual physical examination of this employee/spouse as one of the following (primary care physician, family practitioner, general practitioner, internal medicine, or one of their physician's assistants or nurse practitioners: no specialists allowed such as gynecologists, cardiologists, surgeons, urgent care facility doctors, etc.).

PLEASE COMPLETE ALL INFORMATION BELOW

Date of Annual Physical Examination: ____/____/____ **must be completed between 11/1/18- 10/31/19*

Physician Name (printed):_____ Physician Phone Number:_____

Physician Office Representative Signature:_____
Date:_____

Return this form to WORKING WELL (HC004) or Fax 765-285-8136

All forms must be returned by November 1, 2019 to receive reimbursement.