



MEDICAL MUTUAL®

Physician Screening Form

Member Instructions: Have your healthcare provider to complete the entire Biometric Screening Results section below. You must return this form to Medical Mutual **no later than April 1, 2020.**

Member Information (please print)			
Name:	Birth date:	Employer: Diocese of Toledo - 861250	
Medical Mutual identification number (on ID card):		Phone number:	
Street address:	City:	State:	ZIP:

Biometric Screening Results
Provider: Please provide all biometric results in the chart below. Results will only be accepted for tests completed between September 1, 2019 and April 1, 2020.

	Program Measures:	Program Goals	Provider-tested Results
Date of visit:	Body Mass Index	≤27.49	
Lab collection date:	Height		
	Weight		
	Waist Circumference	Female ≤35, Male ≤40	
	Blood Pressure	≤129/79	
	Total Cholesterol		
	HDL Cholesterol		
	LDL Cholesterol		
	Triglycerides		
	Hemoglobin A1C	<5.6%	
	Tobacco use	Non-Tobacco user	

Provider name (print):	NPI:	Date:
Provider signature:	Phone number:	

Member Acknowledgement

My signature verifies all information supplied is accurate and authorizes the release of medical information to Medical Mutual. I understand any costs associated with an office visit and/or any lab work completed are subject to plan benefits and are my responsibility.

Member signature:	Date:
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Incomplete or late forms will not be accepted or processed.

Send this form to Medical Mutual by **April 1, 2020**. If you have any questions, please call (419) 473-7213.

Email form to: Kate.Rawski@medmutual.com **Fax form to:** (888) 219-8693
Or mail form to: Medical Mutual
 Wellness Team MZ: 01-5B-7500
 2060 E. 9th Street
 Cleveland, OH 44115