City of Montgomery
CAPITAL OF DREAMS.

# City of Montgomery Wellness Program Private Physician Form

**Instructions:** This form is used to comply with the City's Wellness Program by completing your annual Health Risk Assessment (HRA) during January 1st – September 30th each year. If you choose not to participate in the wellness screening at the City Wellness Center, you may submit your screening results through your private physician using this form. You must complete Section 1 of this form and your provider is to complete Section 2. In order to be in compliance for your HRA, this form should be returned to the Risk Management Benefits Office 108 in City Hall by September 30th. If you are not on City insurance, you do not have to complete this form.

***This form does not have to be completed if you have your screening completed at CareHere.***

## Section 1: PATIENT INFORMATION (To be completed by employee)

| Member Name (Please Print) | Screening Date (mm/dd/yyyy) | Male _____ Female _____ Age _____ |
|---|---|---|
| Blue Cross Blue Shield Contract # | Date of Birth (mm/dd/yyyy) | Day Time Phone Number |

**The member will be responsible for any applicable charges for any lab work ordered by the provider.**

I hereby authorize the release of medical information listed in Section 2 to the Risk Management Benefits Office of the City of Montgomery. I understand that this information will be used for statistical purposes only and **will not** be released to any other person or persons. I also understand that this information **will not** be used to deny health insurance coverage to me as an employee of the City of Montgomery.

**Employee Signature** _____ **Date** _____

**IT IS YOUR RESPONSIBILITY TO RETURN THIS COMPLETED FORM TO THE RISK MANAGEMENT BENEFITS OFFICE BY SEPTEMBER 30th. NO EXCEPTIONS!**

## Section 2: BIOMETRICS (To be completed by provider)

☐ Blood Pressure ☐ Height ☐ Total Cholesterol
☐ Weight ☐ Blood Glucose ☐ Body Mass Index (BMI)

**The above mentioned individual was evaluated in my office on _____ and was counseled regarding his/her health risk factor(s).**

**Provider Name: (Please Print)** _____

**Provider Signature:** _____

**Return completed form by either of the following:**

**Fax**: 334-625-2316 **E-Mail**: benefits@montgomeryal.gov **Hand-mail**: City Hall Office 108

**For additional assistance please call 334-625-3692.**