



AtlantiCare 2019 Wellness Activity Certification Form

Patient: Please use this form to document your 2019 Know Your Numbers, Preventive Care Visit, and Lipid Screening. Before submitting please ensure that the entire form, including the date, your provider's signature, provider stamp, and your signature are completed upon submitting to Health Engagement. Information should be clear and legible. **Health Engagement must receive this form by 10/31/2019 in order for you to receive credit for these wellness activities.**

Provider: Complete sections 2 and 3, including provider signature and stamp to serve as adequate documentation of these wellness activities.

SECTION 1 TO BE COMPLETED BY PATIENT SUBMIT BY 10/31/2019

EMPLOYEE **SPOUSE/PARTNER of ATLANTICARE EMPLOYEE**

Your Name: _____ DOB: ____ / ____ / ____

Employee / Policy Holder Clock #: ____ ____ ____ ____ Your "MyAtlantiCare.org" ID Number: _____

Phone: _____ E-mail: _____

SECTION 2: ANNUAL PREVENTIVE CARE VISIT TO BE COMPLETED BY PHYSICIAN SUBMIT BY 10/31/2019

Date of Annual Preventive Care Visit ____ / ____ / ____

- Discussed advanced care planning
- Reviewed preventive screenings
- Reviewed immunizations

SECTION 3: KNOW YOUR NUMBERS CERTIFICATION TO BE COMPLETED BY PHYSICIAN SUBMIT BY 10/31/2019

Are you currently a tobacco user? yes no Are you pregnant? yes no

Blood Pressure: _____ Height: ____ft ____in Weight: _____ BMI: _____

Have you had a lipid screening in the last 5 years? yes no Date ____ / ____ / ____

TOTAL CHOLESTEROL: _____ HDL: _____

Provider Signature _____ Date ____ / ____ / ____

PROVIDER'S STAMP

I hereby authorize my provider to send this form to Health Engagement.

Patient Signature _____ Date ____ / ____ / ____

Your health plan is committed to helping you achieve optimal health. Rewards for participating in this wellness program are available to all benefit eligible employees by way of wellness credits. If you think you might be unable to meet a standard for wellness credits under this wellness program, you might qualify for an opportunity to earn the same wellness credit by different means. Please contact Health Engagement at 609-677-7507 or by emailing wellness@atlanticare.org and we will work with you (and, if you wish, with your doctor) to find a reasonable alternative with the same reward (or a waiver) that is right for you in light of your health status.

IT IS THE RESPONSIBILITY OF THE PATIENT TO ENSURE WE RECEIVE THIS FORM BY 10/31/19 FOR CREDIT.

Confirm submission receipt by viewing your Wellness Activity Tracker at myatlanticare.org.

FAX TO:
609-272-2551

- OR -

MAIL TO:
AtlantiCare Health Engagement
ATTN: WELLNESS
6550 Delilah Road, Bldg. 200, Suite 211
Egg Harbor Township, New Jersey 08234



Questions? Please call Wellness Customer Service at 609-677-7507.