Premier Health
Premier Community Health

WELLNESS REASONABLE ALTERNATIVE FORM

Complete this form if you are seeking a Reasonable Alternative as a way to earn an incentive for your employer's wellness program target(s).

Member Information (please print)			
Name:	Birth Date:	Employer:	
Medical Mutual Identification (ID) number (on ID card):		Phone Number:	
Street Address:	City:	State:	Zip:

Reasonable Alternative Request

Member Check the program measure(s) for which you are completing a reasonable alternative. Include your biometric screening result(s).				**Provider** Describe the counseling and recommended action plan you discussed with your patient to help achieve healthier outcomes.
✓	Program Measure(s):	Program Target(s):	Biometric Screening Result(s):	
	Body Mass Index			
	Blood Pressure			
	TC:HDL			
	Hemoglobin A1C / Glucose			
	Triglycerides			
	Waist Circumference			

Provider Acknowledgement		
My signature verifies all information supplied is accurate.		
Provider Name (Please print):	NPI:	Date:
Provider Signature:		Phone Number:

Member Acknowledgement	
My signature verifies all information given is accurate and authorizes the release of my medical information to Premier Community Health. I understand any costs associated with office visits and/or any lab work completed are subject to my plan benefits and are my responsibility.	
Member Signature:	Date:

Incomplete or late forms will not be accepted or processed.

Please send this form to Premier Community Health by Thursday, October 31, 2019.

You can submit your form one of three (3) ways:

1. By emailing to PCHInformation@premierhealth.com
2. Via secure fax: (937) 641-7061
3. Via mail to the address:

   ATTN: Premier Community Health
   BLDG A – 3rd FLOOR
   3170 Kettering Blvd.
   Dayton, OH 45439