Verification of Professional Care Form

To waive the requirements for the biometric screening and be eligible for the $15 medical plan premium reduction, this form needs to be completed by your physician. The form will be considered incomplete if items in the appropriate section are left blank or your health care provider does not sign this form.

Fax completed forms to: 321.843.6346 no later than November 17, 2017.

***Please complete all of the following information. Print clearly.**

Team Member ID:	First Name:	*Last Name:*
Date of Birth:	Gender: ☐ Male ☐ Female	*Location of employment (ex. Health Central):*

Section I.

I verify that _____ (patient name) is under my professional care for the management of the following condition (s):

☐ ***Hyperlipidemia***
- *Patient's cholesterol is 200 or greater* ☐ *Yes* ☐ *No*
- *Patient's triglycerides are 150 or greater* ☐ *Yes* ☐ *No*

☐ ***Hypertension*** *(BP 140/90 or greater); (BP 150/90 or greater for 65 and older patients)*

☐ ***Hemoglobin A1C***
- *Patient's A1C is 6.5 or greater* ☐ *Yes* ☐ *No*

☐ ***Overweight/ Obesity*** *(BMI greater than 24.9)*

The patient is compliant to the treatment plan including diet, exercise and/or medications ☐ *Yes* ☐ *No*
Patient's condition has not been responsive to diet, exercise and medication ☐ *Yes* ☐ *No*
Patient is unable to tolerate medical treatment at this time ☐ *Yes* ☐ *No*

Section II.

☐ ***Pregnancy***
- *Patient should not be screened at this time due to pregnancy* ☐ *Yes*

Section III.

☐ ***Cholesterol/HDL Ratio***
- *Patient's cholesterol is 200 or greater as a result of a high HDL*

Provider Name: _____ *Facility:* _____

Address: _____ *Telephone/fax:* _____

Health Care Provider Signature: _____ *Date:*_____

If you have any questions regarding the Orlando Health Verification for Professional Care form, contact HR Solutions Center at 321.841.8623.