

WakeMed Health & Hospitals

APPEAL FORM

Disputed Result Appeal: You may dispute your results from your screening/physical by submitting this form along with documentation **including authorized medical lab results (if applicable) and Provider signature**. This form and all supporting documentation must be **submitted no later than 90 days following the date of your screening**.

Program Component Appeal: Employees who are **medically unable** to meet the standard for their company's wellness program due to unique circumstances may have a Licensed Medical Professional waive individual program components or the entire program.

INSTRUCTIONS FOR APPEAL:

Please complete the entire participant section and discuss with your medical provider. Have your Provider complete the **Provider Section** on the reverse side. Once the form is completed, submit to Liza MacDonald at WakeMed (Phone: 919-350-5909) via secure email, fax or mail:

Email: MobileWellness@wakemed.org **Mail:** Liza MacDonald, Corporate and Community Health,
Fax: 919-350-6739 3000 New Bern Ave.
Raleigh, NC 27610

This form must be submitted no later than 90 days following the date of your screening.

Patient First Name: _____

Patient Last Name: _____

Date of Birth: _____

Phone number: _____

Email: _____

By submitting and signing this form, I verify that the information supplied is true and complete, and there has been no attempt to knowingly provide any false, incomplete, or misleading information.

Participant Signature: _____ Date: _____

OTHER SIDE TO BE COMPLETED BY PROVIDER

PROVIDER SECTION (COMPLETE THE SECTION THAT APPLIES)

Disputed Result: Please complete and sign below, certifying that these are the authentic results of the above-named individual:

<u>DISPUTED CATEGORY</u>	<u>PROGRAM GOAL</u>	<u>MEDICAL LAB RESULTS</u>
Blood Pressure	≤ 130/85 mmHg	
BMI* or Waist Circumference (WC)	≤ 30 kg/m ² Female: ≤ 35 in Male: ≤ 40 in	BMI: _____ Height: _____ Weight: _____ WC: _____
Glucose Or A1C (attach lab report)	≤ 105, Diabetic ≤ 130 or <5.7, Diabetic <7 or Reduction by 10 mg/dL or 0.3% from prior year	
Tobacco	Negative	

**If BMI is being disputed, please provide height and weight.*

Program Component Appeal: Please complete and sign below, certifying that the above-named individual is medically unable to meet one or more of the standards of their wellness exam.

Waived Individual Program Component(s)	Brief explanation of why the member cannot complete (REQUIRED)
<input type="checkbox"/> Blood Pressure Measurement	
<input type="checkbox"/> BMI and Waist Circumference Measurement	
<input type="checkbox"/> Glucose Test	
<input type="checkbox"/> Tobacco Use	
<input type="checkbox"/> Entire program: employee is unable to participate in the wellness program at this time.	

Provider Name (printed): _____

Provider Signature: _____

Practice Name: _____

Provider Phone Number: _____ Date: _____

****Note: Forms submitted without the signature of a Provider will not be approved****