Healthy Tomorrows Reporting Form
Plan Year 2019

PEIA ID # (from medical ID card)	7	7	0	0						

Policyholder Full Legal Name:_____

Address _____

City, State, Zip_____

For Plan Year 2019 (July 1, 2018 – June 30, 2019), the PEIA Finance Board has authorized a premium increase for any PEIA PPB Plan policyholder who does not pick a Primary Care Provider (PCP), report the following biometric data, and have these numbers within the acceptable ranges before the end of Open Enrollment in 2018 (mid-May 2018). Waist circumference must be reported, but does not affect premiums. All active employees and non-Medicare retired policyholders in any PEIA PPB Plan must report this data. Spouses, dependent children, Medicare retirees and members of The Health Plan HMOs and PPO **do not** have to comply.

Instructions for Provider

1. Please report the biometric values below.
2. Complete the contact information, mark the appropriate box in the Medical Certification, sign and date.
3. Return completed form to patient.

All fields are REQUIRED. Forms missing data will be rejected. Acceptable values shown in red.

Blood Pressure:	Systolic >140 ☐	≤140 ☐
	Diastolic >90 ☐	≤90 ☐
Total Cholesterol:	>245 ☐	≤245 ☐
Glucose:	>125 ☐	≤125 ☐
Waist Circumference (in inches):	Male >40 ☐	≤40 ☐
Waist circumference must be reported, but does not affect premium	Female >35 ☐	≤35 ☐

Provider Contact

Name of Provider: _____ Phone Number: _____

Address: _____

Medical Certification: I certify that the patient indicated above:

☐ has received the measurements indicated above, and meets the standards set by PEIA.

☐ has received the measurements indicated above, and does not meet the standard set by PEIA

☐ in my best medical judgement, is unable to meet the blood pressure, cholesterol and/or glucose standards set by PEIA because of a unique clinical circumstance with this member. Therefore, I request this member not be subject to the premium increase because they are not able, medically, to make the lifestyle or medication changes required to get them to goal.

_____ _____

(*Signature of Provider or Authorized Representative*) *(Date of Service)*

Please return this form to: **PEIA Healthy Tomorrows, 601 57th St, SE, Charleston, WV 25304-2345**