

DRIVETIME WELLNESS FORM 2012



Employee/Spouse/Partner Name: _____

EE ID#: _____

Circle One: Employee Spouse/Partner

Dear Provider:

DriveTime employees receive discounted medical premiums for participating in our company Wellness Program and meeting certain biometric levels. Your name and signature below verifies that your patient has completed and undertaken both of the following procedures:

Annual Physical:
Standard Health Examination

Biometric Testing: (Please see table below)
BMI
Blood Pressure
Cholesterol (Blood draw sent to lab)

Patients who are pregnant or being treated for chronic health conditions may also qualify by signing a separate "Wellness Exception" Form at the time of this visit.

Wellness Program Requirements	
Biometric Category	DT Requirement
Blood Pressure	139/89 mm/Hg or less
Cholesterol	200 mm/dL or less OR 4.0 Total/HDL or less
Body Mass Index (BMI)	29.9 kg/m ² or less


Patient Name: _____

Provider Name: _____

NPI#: _____

Office Phone: _____

Date: _____

 Fax this completed form to **888-505-7130**

