Dear Health Care Provider,
Your patient is participating in a wellness initiative sponsored by the Huron-Erie School Employees Insurance Association. As part of the employee wellness initiative, we are asking a licensed health care professional (MD, DO, NP, PA) to complete the clinical measurement and provider information below. We appreciate your assistance in completing this form. Thank you for supporting your patient's personal wellness plan.

COMPLETION DIRECTIONS

1. **Take this form to your Physician and ask them to complete the PROVIDER INFORMATION sections**
2. **Enter information into the MMO health assessment:**
   i. Visit MedMutual.com/member and log into *My Health Plan*
   ii. Click *Take the Health Assessment Now*
   iii. Select *Agree and take Health Assessment in English* [or Spanish] and click Submit
   iv. Click Get Started and follow the instructions to complete the assessment
   v. When completing, do NOT click the *back* button because you may receive an error and be prompted to sign in and start over.
   vi. When you've completed all the questions, you will see a congratulatory message. **PRINT THIS PAGE FOR YOUR RECORDS.** You can view and print your results in an Individual Profile Report
3. **Provide the Health Assessment Completion Page AND the section below the dotted line ONLY to [TREASURER] as proof of completion. [INSERT INCENTIVE INFORMATION IF APPLICABLE]**

----------**KEEP THIS SECTION FOR YOUR PERSONAL RECORDS**----------

PERSONAL INFORMATION – (TO BE COMPLETED BY *PATIENT*)

Date of Appointment: _____ (Exam must have been conducted on/after **xx/xx/xx**)

First Name: _____ MI:_____ Last Name: _____

Gender: _____ Date of Birth: _____ Phone:_____

Address:_____

CLINICAL MEASUREMENT- (TO BE COMPLETED BY *PHYSICIAN*)

Height	_____ ft _____in	Blood pressure – Systolic (high #)	_____
Weight	_____(lbs)	– Diastolic (low #)	_____
Total cholesterol level	_____(mg/dL)	Triglyceride level	_____(mg/dL)
HDL cholesterol level	_____(mg/dL)	Glucose level	_____(mg/dL)
LDL cholesterol level	_____(mg/dL)		

✂----------**CUT HERE**----------✂

Submit this section along with verification of your completed health assessment to your [TREASURER] in order to receive [INSERT APPLICABLE INCENTIVE INFORMATION]

PROVIDER INFORMATION- TO BE COMPLETED BY PHYSICIAN

Physician Name (Print): _____ Phone: _____

Office Address: _____

Physician Signature: _____Date:_____

AUTHORIZATION:

Patient Signature: _____ Date: _____