Outcomes-Based Program Appeal Form

Instructions for patients and Health Coaches/Primary Care Providers

Your employer is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you did not fulfill the requirements of the program but believe you made progress toward the program goals, you may be eligible to receive the incentive by submitting an appeal.

The instructions below should be used by both patients and a CareATC Health Coach or Primary Care Provider for completion of this program appeal form.

INSTRUCTIONS:

Patients

- Print a copy of this form and bring it with you to your CareATC Health Coach or Primary Care Provider, along with your PHA data from the program years in question. You must make an appointment with the Health Coach in advance.
- Please complete all fields in the top section, including your date of birth.
- Please write clearly and sign the form. Forms that are not legible or without signature may be returned.

CareATC Health Coach/Primary Care Provider

- Review the parameters for earning the incentive.
- Review the PHA data from both the baseline and comparison year.
- Complete all fields relevant to PHA values, including calculating the reduction percentages.
- Please complete, sign and date the form.

Please complete this form and return to CareATC by:

- Fax: 860-606-9588
- Email: Wellness@CareATC.com

If you have questions about completing this form, please call CareATC at 888-930-7451.

Commitment to Patient Privacy and Confidentiality:
CareATC adheres to the legal duty of patient confidentiality as outlined in HIPAA Security Rule (45CFR Part 160 and Part 164, subparts A and C) for the maintenance and transmission of all patient records. The privacy and confidentiality of our patients are protected under federal HIPAA Regulations, state laws and regulations, and the Ethics Codes of mental health professions. Access of patient records and transmissions by third-party entities, (i.e., employers or family member) is prohibited. Patient information may not be disclosed without the explicit and informed consent of the patient and authorization by their clinician.

4500 South 129th East Avenue, Tulsa, OK 74134 | T: 888-930-7451 | F: 860-606-9588 | www.careatc.com

Outcomes-Based Program Appeal Form

TO BE COMPLETED BY THE PATIENT:

Employer: Lancaster-Lebanon IU13

Employee or Spouse: <Select One>

First Name: _____

Last Name: _____

Phone Number: _____

Email: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

TO BE COMPLETED BY A CAREATC HEALTH COACH/PRIMARY CARE PROVIDER :

Wellness Goal Progress

Wellness Goal		Baseline	Most Recent	Ideal	% Change
Date of lab values:					
☐	Body Mass Index			< 27.5	
☐	Achieve a healthy waist circumference			< 37 Male	
				< 34.5 Female	
☐	Achieve healthy blood pressure			< 125/80	
☐	Achieve a healthy cholesterol ratio			< 4.5	
☐	Achieve a healthy LDL cholesterol			< 115	
☐	Achieve a healthy fasting glucose			< 120	
☐	Achieve tobacco abstinence/cessation			Nonsmoking	
	Complete Health Screening			Complete	

☐ I recommend that this patient earn the incentive due to the reductions in the following areas*: _____

_____.

☐ I do not recommend that this patient earn the incentive due to the following reasons: _____

_____.

* Please note that appeals will only be considered for those who maintained the same Health Risk Score and must show a reduction in at least one metric. Those who increased their Health Risk Score must see their Physician and complete the Reasonable Alternative and Waiver form to be considered eligible for an incentive.

Health Coach/Provider Name (Print): _____

Email: _____

Phone: _____

Coach/Provider Signature: _____ Date: _____

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CareATC