Rockwell Automation Screening Appeal Form

PLEASE PRINT IN DARK INK. INITIAL ALL CROSS-OUTS.

Participant Information

If one or more of the incentive criteria have not been met, you have the opportunity to talk with your health care provider and submit an appeal form. Your health care provider must complete and sign this form.

Name		Last 4 digits of Social Security Number
Street Address		City
State	Zip Code	Date of Birth
Daytime Phone (area code first)		Home Phone (area code first)
Employer Name Rockwell Automation		By signing this form, I verify that the information supplied here is accurate and complete.
Participant Signature	Date	

Physician Information

A health management program is offered to help employees improve their overall health. Employees may earn 2018 medical premium credits of $50 for each of the screening targets below that are met or successfully appealed with your approval. In order for your patient to receive the financial incentive, please review any missed biometric targets and, if appropriate, discuss your recommended treatment and/or lifestyle changes. In column B, please mark the health measurements that you approve for appeal.

Category	Health Measurement (Column B)	Employer's Target	Physician Statement
Weight	BMI (Body Mass Index) ☐	18.5-25 BMI or in-range for waist	For the Health Measurements checked at left, please grant the incentive. I have discussed recommended treatment and/or lifestyle changes with the patient.
	Waist Measurement ☐	Men less than 40" Women less than 35"	
Blood Pressure	Blood Pressure ☐	120/80 mmHg or less	
Cholesterol	Total Cholesterol ☐	Less than or equal to 199 mg/dL	
	Total Chol./HDL Ratio ☐	Less than 5	
Blood Glucose	Fasting Glucose ☐	70-100 mg/dL	
	Non-Fasting Glucose ☐	70-180 mg/dL	
Cardiorespiratory fitness*	Recovery Heart Rate in Beats Per Minute ☐	"Excellent" to "average" for age and gender	

Physician: Appeals cannot be processed without your full signature, printed name, date and phone number.

Physician Signature	Date	By signing this form, I agree that I have reviewed the above individual's screening measurements.
Physician Printed Name		
Phone Number (area code first)		

*Measured with the YMCA three-minute step test or Rockport one-mile fitness walking test.

Submission:

☐ Complete this form in full. Incomplete or late submissions may delay or eliminate your patient from incentive eligibility.

☐ Submit this form to arrive at StayWell by **Dec. 31, 2017** using one of the following methods:

Mail to: StayWell Health Management
Attn: Screening Team
PO Box 21427
St. Paul MN 55121

Fax to: 1-800-895-1860
Please **do not** use a fax cover page
*Allow 10 business days for processing