Medical Exemption Form





INSTRUCTIONS for Active Employees and Retirees (OGB Blue Cross subscribers/policyholders)

If you did not qualify for the wellness incentive or are unable to participate in the onsite preventive checkups during the program year of 9/1/19 to 9/30/20 because you were pregnant at the time of the checkups, as an alternative you may work with your physician to develop a plan to maintain or improve your health. Complete the form below, have it signed by your personal physician, and fax it to Catapult Health at 877-885-9904 by 5:00 PM Central Time on September 30, 2020.

PLEASE PRINT CLEARLY. If illegible, your information will not be recorded.

PATIENT'S NAME:	M.I. Last	DATE: / /	DATE OF BIRTH: _	/ /
First	M.I. Last	Mo / Day / Yea	r	Mo / Day / Year
PATIENT'S SIGNATURE:		_ PHONE NUMBER:()	-
PATIENT'S E-MAIL:			BCBS LA Member ID:	
ADDRESS: Street or PO Box		City	Ctata	7io
Street or PO Box		City	State	Zip
Instructions for Physician				
The above named individual is elig of Group Benefits. He or she did no pregnant at the time of the onsite the Office of Group Benefits accommon improve his or her health. We do what your plan is for your patient	ot achieve the requestion of achieve the requestion of the checkups and thus modates personal not need to know if	ired health standards the ineligible to participate physician recommenda	nat are a part of the properties. In compliance with History tions for your patient	rogram, or was HIPAA requirements, to maintain or
By signing below you acknowledg above or that you have been prov		· · · · · · · · · · · · · · · · · · ·		tient who is named
Physician's Name (Print)	 Physician's Si	gnature	Today's Date	

This completed form must be received by Catapult Health by 5:00 pm on September 30, 2020

VIA MAIL: Catapult Health - PCP Form, 8144 Walnut Hill, Suite 1120, Dallas, TX 75231

VIA FAX: 877-885-9904 (no cover page is needed)