Johnson County Medical Waiver Form

Please print this form, bring to your health care provider to complete, and return to Healthy County by fax or email. Make sure you complete and submit this waiver by **July 31, 2020**. Once form is received, employee will be sent confirmation of receipt. **Please note that a Health Screening Results Form with biometrics must also be completed in addition to a Medical Waiver Form.**

Healthy County Together. Better. Stronger.
Texas Association of Counties Health and Employee Benefits Pool

PARTICIPANT:
Please fill out Section 1.

HEALTHCARE PROVIDER*:
Please fill out and sign Section 2.

SUBMIT FORM TO:

Email: johnsonwellness@county.org
Fax: 1-512-481-8481
Mail: Texas Association of Counties
Attention: Healthy County
PO BOX 2131
Austin, TX 78768

IMPORTANT:
1. All information is required to process this form.
2. The form must be received no later than **July 31, 2020.**
3. Questions? Email johnsonwellness@county.org or call Healthy County at 1-800-456-5974.

***For purposes of this form, "Healthcare Provider" includes a licensed health professional, for example: MD, DO, PA, or NP.**

Section 1: Completed by participant

Name: ______________________________
(FIRST) (MI) (LAST)

Gender:
○ Male
○ Female
○ Other

Status:
○ Employee
○ Spouse/Domestic Partner

Date of Birth: ☐☐ - ☐☐ - ☐☐☐☐
(MM/DD/YYYY)

BCBSTX ID: ______________________

Email Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Phone Number: (☐☐☐)☐☐☐ ☐☐☐☐ Please circle preferred contact method: Email Phone

Section 2: Completed by Healthcare Provider

I acknowledge that the Johnson County employee stated on this form did not meet 3 out of 5 biometric outcomes listed below. This employee is working toward their health goals under my supervision.

Employees must Complete Biometric Screening + Meet 3/5 Outcomes
- Blood Pressure <130/85 kg
- Waist Circumference ≤40 (MEN); ≤35 (WOMEN)
- Fasting Glucose ≤100 mg/dl
- Triglycerides ≤150
- HDL >40 mg/dl (MEN); >50 mg/dl (WOMEN)

____
Healthcare Provider's Name (Please Print)

(   ) ______________________
Phone

____
Office Address

City/State/Zip

____
Healthcare Provider's Signature

Date: ☐☐ - ☐☐ - ☐☐☐☐
(MM/DD/YYYY)

If you have an office stamp, please apply here:

Do not submit this request form to your Human Resources department. All information provided is kept strictly confidential, is protected by law, and is not disclosed to your employer. Results provided do not preclude eligibility in any benefit program.