Biometric Exception Form

This form should be completed to receive credit for your biometric measurements when you do not receive your biometric measurements through a Quartz screening event. Labs conducted outside of the federal guidelines for preventive services or for diagnostic purposes may be subject to member cost share in the form of deductibles and / or coinsurance.

STEP 1: YOUR INFORMATION (Required)

Last Name _____ MI _____ First (Full Legal Name) _____ Date of Birth (mm/dd/yyyy) _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____ ☐ Check to receive email confirmation

☐ Female ☐ Male ☐ Subscriber #___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Company Code ___ ___ ___ ___ ___ ___

(This is the nine digit subscriber number and two digit person code found on y our ID card.) *(6-digits; the group for which you are submitting this form)*

STEP 2: REASON FOR THE EXCEPTION (Check One Box Below)

Select one option below and complete the information required for that exception.

☐ **I am pregnant**. ☐ **I am postpartum (within one year of delivery date).** Delivery Date: _____.
Have your practitioner complete the Practitioner Information (Section A) ***Or*** Have your employer complete the Employer Information (Section B).

☐ **I have had my biometric measurements taken by my practitioner within the current calendar year.** Have your practitioner complete the Biometric Screening Information (Section C) and the Practitioner Information (Section A) ***Or*** Attach a copy of all of the verified biometric screening information requested in Section C, including your name and the date of service, to this form. ***Note:*** *Biometric measurements printed from MyChart, a different online medical record or on letterhead from your clinic are acceptable. Forms that do not include all of the required biometric measurements and clinic information will be returned for completion.*

☐ **I attest my biometric measurements are within acceptable medical guidelines per my practitioner and do not need to be re-measured this year**. Sign your name below to attest and have your practitioner complete the Biometric Screening Information (Section C) and the Practitioner Information (Section A).

Member's Signature _____ Date _____

☐ **I am participating in the Family Medical Leave Act (FMLA)**. Have your employer complete the Employer Information (Section B).

☐ **I am on medical leave**. Have your employer complete the Employer Information (Section B).

SECTION A: PRACTITIONER INFORMATION

Name of Clinic and Practitioner (please print) _____

Practitioner's Signature _____ Today's Date _____

SECTION B: EMPLOYER INFORMATION

(Signature IS required for FMLA and Medical Leave; signature for pregnancy and postpartum ONLY required if doctor does not sign.)

Company Name _____ Employer's Signature _____ Today's Date _____

SECTION C: BIOMETRIC SCREENING INFORMATION (Complete All Fields Below)

Screening Test	Result	Date of Result	Please Check the Correct Box Below Based on the Test
Total Cholesterol			☐ Fasting ☐ Non-Fasting
LDL Cholesterol (only required if fasting)			☐ Fasting ☐ Non-Fasting
HDL Cholesterol			☐ Fasting ☐ Non-Fasting
Triglycerides (only required if fasting)			☐ Fasting ☐ Non-Fasting
Glucose			☐ Fasting ☐ Non-Fasting
Blood Pressure			
Height (needed to calculate BMI)			
Weight	lbs.		

STEP 3: SEND YOUR COMPLETED FORM AND ANY DOCUMENTATION (IF APPLICABLE) TO QUARTZ

Mail: Quartz, Attn: Health Screening, 2650 Novation Pkwy, Fitchburg, WI 53713

Email: Wellness@QuartzBenefits.com

Disclaimer: If you choose to submit this form via email, be advised that many email services are unsecure (unencrypted) and there is some level of risk that your PHI could be read or otherwise accessed by a third party while in transit.

Questions? Contact a Quartz wellness representative at **(800) 362-3310**.

FOR OFFICE USE ONLY:

Date entered: _____ Data entered by: _____

Date audited: _____ Data audited by _____