MEDICAL EXEMPTION REQUEST FOR REASONABLE ALTERNATIVE

Patient Information:

Last Name: _____ First Name (legal): _____ Middle Initial: _____

Date of Birth: _____ Employee # _____ (or indicate "spouse")

Phone Number: _____ Email: _____

Medical Exemption

I am requesting a waiver or medical exemption based on my current health status. I understand I will be given a reasonable alternative if I qualify. I understand a detailed statement from my primary care healthcare provider explaining why it is medically inadvisable for me to attain the goal and their signature are required.

Criteria Appealing (Required): Please check all that apply

✓	Appeal Criteria	Original Result	Saint Francis Goal
	Blood Pressure		
	Glucose		
	A1C		
	LDL Cholesterol		

✓	Appeal Criteria	Original Result	Saint Francis Goal
	Triglycerides		
	BMI		
	Tobacco Use		
	Exercise		

Must be completed by provider – MD, DO, PA, NP or APN

Medical Waiver or Exemption:

Provider Statement: *(Please include criteria(s) being requested for exemption and the reason for the waiver or medical exemption.*

Provider Signature: _____Date:_____

Provider Printed Name: _____

Office Address: _____

Office Phone Number: _____

By signing, I verify that the information supplied by myself or my representative here is true and complete. I also authorize the release of any medical information that Healthy Rewards might need in order to process this exemption.

Participant Signature: _____Date: _____

Exemption forms must be scanned and uploaded to your ManageWell account along with any lab verification and/or documentation/statements as appropriate. If you have questions, please email or call Wellness at healthyrewards@sfmc.net or 573-331-5970.