



2020 Medical Exemption

Individuals who cannot complete the steps below may have their physician submit this completed Medical Exemption to qualify for a premium discount. Does not apply to tobacco use.

PATIENT INFORMATION (to be completed by the patient or the patient's representative)

Your Name (please print): _____ Birth Date: ____/____/____

Your Email: _____ Phone: ____/____/____

Are you the subscriber for Miami's health plan (health premium deducted from your pay check)?

YES. Enter your MU uniqueID: _____
(This is your Miami uniqueID, for example, employjn)

NO. Enter your MU uniqueID: _____
(This is your spouse's MU uniqueID followed by "_sps", for example, employjn_sps)

Your MU uniqueID can be found in your Healthy Miami account under "My Profile."

By signing below, I give consent to my physician to release this information to TriHealth and I understand it is my responsibility to ensure that TriHealth receives this exemption form.

Signature: _____ **Date:** _____

PHYSICIAN STATEMENT

This patient is unable to, or advised not to, complete the following actions (check all that apply):

Biometric Health Screening, including measurement of blood pressure, height, weight, and a fasting blood draw for total cholesterol, HDL, LDL, Triglycerides, glucose and/or A1C.

This exemption is: Annual (this year only)
 Continuing (this and every year following)

Preventive Screening(s) by Gender and Age (check all that apply):

Screening	Annual exemption (this year only)	Continuing exemption (this and every year following)
Cervical cancer	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>

Primary Care Physician Wellness Visit
(Example: Patient is regularly seeing a specialist or PCP for specific care and/or treatment.)

This exemption is:
 Annual exemption (this year only) Continuing exemption (this and every year following)

Provider Name (print): _____ **Phone:** _____

Provider Signature: _____ **Date:** _____