

PCP Form | Wellness Discount



Snell is committed to a culture that enhances the quality of life for our employees and their families. All Snell employees are encouraged to participate to earn their "Wellness Discount". All information collected for the "Wellness Discount" will be kept confidential and handled in accordance with HIPPA privacy requirements when applicable. Submit form to healthsnellventures.com.

Wellness Discount Requirement: Annual preventative exam with primary care physician or equivalency by October 31st. Wellness Discount will be seen on next plan year premiums after March Open Enrollment. **Use of this form is mandatory to participate; no substitutions are accepted. **

Physician Instructions: As a part of the Snell Wellness Discount program, employees can earn a "Wellness Discount" on their insurance premiums. To earn this discount, they must complete their annual preventative exam. Once the preventative exam is complete, please sign and date this form then return it to our employee so that they may get credit. Snell is NOT requesting any medical records or PHI pertaining to this exam.

Annual Exam Description:

The annual preventative exam should include a medical and health history discussion, a lipid panel, glucose test, blood pressure, height, weight, and BMI. Yearly preventative exams should be scheduled following the recommended guidelines. If other tests/services are conducted at this appointment, the employee may be responsible for out-of-pocket costs based on their insurance plan.

Verification: Physician's Name:

_____ Date:

_____ I verify

that _____ (patient's name)

completed their annual preventative exam on the date specified above.

Employee Release: I, _____, (Employees name)

authorize my primary care physician listed in "Verification" section of this form to release the date of my annual preventative exam for use in the Snell Wellness Discount program.

I understand that my participation in the **Snell Wellness Discount program is voluntary**, and that the requirement is to complete an annual preventative exam with my primary care physician. If I choose to participate in any other services or screenings with my primary care physician, I will be responsible for out-of-pocket costs.

Employee Signature: _____

Date: _____