emplify HEALTH

Due in Population Health by October 16, 2026 to earn the Wellness Incentive for the 2027 benefit year.

Wellness Incentive Health Manual Verification Form

IMPORTANT: Use this form to demonstrate that you have met the requirements for the annual Wellness Incentive. **Please do not submit the form unless you have fulfilled all applicable screening requirements.** This form must be submitted annually.

SECTION 1 TO BE COMPLETED BY HEALTH PLAN PARTICIPANT

→ **Step 1: Please complete all information below:**

Employee Legal Name:________________________________
(Employee that carries plan coverage) *(Please Print)*

Participant Legal Name:______________________________ **Date of Birth:** ____/____/____ **Sex at Birth:** ☐ Male ☐ Female
(Either Employee, Spouse or Domestic Partner) *(Please Print)*

I am a(n): ☐ Employee (Employee ID #___________) ☐ Spouse/Domestic Partner on Plan (email:______________________)

→ **Step 2: Participant Acknowledgement**

I am participating in the Emplify Health Wellness Incentive and hereby authorize my Provider's office to complete this document on my behalf. I understand that Emplify Health will not condition my treatment, payment for health care, or eligibility for enrollment in the health plan on whether I submit this form. However, I understand that my eligibility to receive the Wellness Incentive is conditioned upon proof of completion of the applicable screening requirements. If I choose not to submit such proof, I may still enroll in and receive benefits under the health plan, but I will not receive the Wellness Incentive for the applicable plan year. The data submitted will be securely stored by Emplify Health Population Health team for purposes of maintaining the Wellness Incentive program, and the only information released to the health plan will be whether I have completed the required screenings. **I also acknowledge that it is my responsibility to ensure my Manual Verification Form is completed by my Provider's office and is received by Population Health by October 16, 2026.**

______________________________ __________________
(Participant Signature) (Date)

→ **Step 3:** Have your Provider complete Section 2. **No appointment is needed if you are up-to-date with the preventive screenings.**

SECTION 2 TO BE COMPLETED BY PRIMARY CARE PROVIDER'S OFFICE

Please provide the most recent date the participant completed each screening, write "N/A" if the screening does not apply, or specify an approved exemption reason from the list below. **All screenings must include a date, "N/A," or an approved exemption reason.** Additional or more frequent screenings are not required to qualify for the incentive; however, your provider may recommend a schedule tailored to your individual health needs. It is advised that you adhere to your provider's recommendations.

Requirements	Criteria	Screening	Date of Last Completion, NA, or Exemption Reason
Wellness Exam	Men and Women, All Ages	Physical exam in primary care	
Colorectal Screening	Men and Women, Ages 45-75	FIT	
	Men and Women, Ages 45-75	Cologuard	
	Men and Women, Ages 45-75	Sigmoidoscopy	
	Men and Women, Ages 45-75	Colonoscopy	
Cervical Cancer Screening	Women, Ages 21-29	Pap smear	
	Women, Ages 30-64	Pap smear with HPV	
Breast Cancer Screening	Women, Ages 40-74	Mammogram	
Lipid Screening	Men and Women, Ages 20+	Cholesterol panel	
Glucose (Diabetes) Screening	Men and Women, Ages 35+	Glucose test or A1c	

Approved Exemptions: Surgical removal of both breasts exempts mammogram; removal of cervix exempts cervical cancer screening; currently pregnant or within 6 months postpartum at time of form completion, exempts wellness exam, lipid screening, mammogram, and colon cancer screening; currently breastfeeding exempts mammogram.

Signature of Provider:

____________________ ____________________ ____________
(Name) Please print. (Signature) (Date)

SECTION 3 TO BE COMPLETED BY HEALTH PLAN PARTICIPANT

Submit form to Population Health by October 16, 2026. Forms can be emailed to Population Health at wellness.incentive@emplifyhealth.org, mailed to Population Health (Attn: Wellness Incentive) at 1900 South Avenue, Mailstop FS5-001, La Crosse, WI 54601 or faxed to 608-775-2530.