## PROGRAM APPEAL



Eligible members who are medically unable to participate in their wellness program due to unique circumstances may have a Licensed Medical Professional waive individual program components or the program in its entirety.

## **INSTRUCTIONS FOR APPEAL**

- The Member Information section of the Appeal Application should be filled out by the member.
- The remainder of the form must be completed and signed by a Licensed Medical Professional.
- Upon completion, the member or the Licensed Medical Professional submits the waiver by mail, fax, or internet upload (upload by member only):

Viverae

Attn: Screening Services Department 10670 N. Central Expwy., Suite 250 Dallas, TX 75231

Secure Fax: (855) 292-8662 Phone: (888) 848-3723

Upload to connect.viverae.com

## **APPEAL DEADLINE**

Viverae must receive the completed waiver by 07/30/2018.

Viverae will evaluate the waiver to verify that all necessary information is complete. Approval or denial of the waiver will only apply to the applicable plan year. This process must be completed for each new wellness program year including resubmission of the Program Alternative Waiver form.

## **PROGRAM APPEAL**

Member Information (Please Print)

First Name	Middle Initial		Last Name	Gen	der (Male/Female)
		ntative	e or I have supplied is true and comp	olete, c	Employer and there has been no
to be completed by	' A LICENSED MEDICAL PRO	FESSI	ONAL:		
ENTIRI Program may ind	ROGRAM COMPONENT(S) OR EPROGRAM clude by not limited to: cate by	Briei	explanation of why the member car complete (REQUIRED)	nnot	VIVERAE USE ONLY
☐ Member Health Asse questions about speci	essment (MHA) – consists of fic lifestyle habits				☐ Approved☐ Denied
☐ Biometric Screening					□ Approved □ Denied
□ Preventive Care Cor	mpliance				□ Approved □ Denied
videos, health challenge t	mbination of educational online racking and questionnaires nteraction with a Health Coach c Condition Care Plan)				☐ Approved☐ Denied
	essation Program – a four- es (if applicable to member's rogram)				□ Approved □ Denied
□ Entire Program – the participate in their well	member is unable to ness program at this time.				□ Approved □ Denied
Licensed Medical Professional Name (print):			Licensed Medical Professional Signature:		
License Type/Number:			City/State:		
Phone Number:			Today's Date:		
Note: Forms submitted	d without the signature of a	Licer	sed Medical Professional will not l	be app	oroved.
	Appeal F	Reviev	v - Viverae Use Only:		
☐ Chief Clinical Office	r 🗆 Chief Medical C	fficer	Date:		
Signature:					
Notes:				_	

