

2026 Madison County Wellness Visit Confirmation Form

(Please complete a separate form for each member receiving a wellness visit)

As part of the Madison County Wellness Program, employees and their spouses who meet program participation guidelines will be eligible for a premium discount for **7/1/2026-7/1/2027**.

Take this form with you to your scheduled annual wellness visit to be completed and signed by your doctor.

The visit needs to have been completed between the dates of **7/1/2025-7/1/2026**. New hires will have 2 months to provide a completed form by their doctor to be eligible for the premium discount, until form is received new hires will be charged the non-wellness rate. New hire will be reimbursed overage payment if/once Wellness form is received.

It is the participant's responsibility to submit the Wellness Visit Confirmation Form to Madison County Human Resources by **7/1/2027** to qualify for the premium discount.

PATIENT'S information (to be completed by patient):

Patient's Name: _____ Male ☐ Female ☐ DOB: _____

Patient's Address: _____

Patient's Phone Number: _____ Relationship: Employee ☐ Spouse ☐

I authorize the physician's office completing this form to release the information below to my Human Resources department.

Patient's Signature: _____

DOCTOR'S information (to be completed by doctor):

Date of Wellness Visit: _____

- **Preventative Exam completed**
☐ Yes ☐ No
- **Annual screening (blood pressure, BMI, etc.) completed, if appropriate**
☐ Yes ☐ No
- **Comprehensive Metabolic Panel (CMP) completed, if appropriate**
☐ Yes ☐ No

Note: Some testing and/or labs ordered during your wellness exam may be subject to a co-pay. If your doctor has a concern and orders diagnostic testing and/or labs during your exam you may be held financially responsible. Be sure to discuss with your doctor.

I hereby certify that the above information is correct.

Physician's Name: _____

Physician's Signature: _____ Date: _____

Office Phone Number: (_____) _____