Physician Certification Form

Expanded and Streamlined Wellness Credit Program

Attention CMSD Employees:

At this time, non-bargaining staff and the following bargaining groups have opted-in to this expanded wellness credit program: SEIU 1199, Local 777, Local 860, OPBA, Trades, and Local 436.

In an effort to simplify our wellness program moving forward, we are looking to eliminate the physician certification form submission process. **You won't need to submit this form to receive your wellness credit for the 2027 plan year!**

To make this possible, we've partnered with our Medical carrier, Aetna, to remove the need for form completion, account log-ins, and online submissions. You will need to print and bring this form to your preventative exam, but will not be required to complete additional steps beyond that.

1. Complete the attached Health Risk Assessment form. Visit the Cleveland Metropolitan School District Wellness page at www.mycmsdbenefits.com.

2. Attend any of the following preventive exams between the dates of 11/1/25 – 10/31/26 and provide the enclosed form with you for your physician to complete.
    a. Qualified preventive exams:
        - Routine Physical/Wellness Exam
        - Routine Colonoscopy
        - Routine Mammogram
        - Routine Pap

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Revised 9/24/26

Physician Certification Form

3. In completing this form, your physician will submit your preventive care exam to the claims department coded as "preventive" and Aetna will notify your HR team accordingly in order to give you the wellness credit.

*If your physician checks the "diagnostic" box, skip to step 5

4. YOU'RE DONE! No need to submit the form your physician filled out anywhere! *We do recommend you hold on to it just in case you need to reference it later!*

5. **If your physician checks the "diagnostic" box—you have another step to take!** This form is for preventive exams, therefore, if your physician codes your appointment as **diagnostic**, Aetna will not be able to confirm your participation in a preventive care exam—Which is where this form comes in handy!

IF your physician checks the "diagnostic" box, you will need to submit your form to the Healthworks portal in order to confirm your participation in a preventive care exam. Forms will be due to the portal 10/31/26. Visit the wellness page for more information/instructions on accessing the Healthworks portal.

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ANNUAL PHYSICAL VERIFICATION FORM INSTRUCTIONS

Thank you for choosing to participate in the wellness program being offered through Cleveland Metropolitan School District. Your doctor will need to sign this VERIFICATION form so that you will receive credit.

- This form is for appointments between **11/1/2025-10/31/2026**
- Take the Annual Physical Verification Form to your Primary Care Physician for your annual visit by **10/31/2026**.
- Ask your Primary Care Physician to complete the form.
- Follow instructions at the bottom of the form to submit for credit.
- HealthWorks will record that you have completed your annual visit. Please allow 3 business days for the processing of your form.
- Your employer will receive confirmation that you have completed this portion of your wellness program

Thank you,
The IH21/HW Central Division Team

Please allow 3 business days for processing of forms.
Questions? Call 513-751-1288

INTEGRATED HEALTH 21 | HealthWorks Central Division

ANNUAL PHYSICAL VERIFICATION FORM

Cleveland Metropolitan School District

Form for appointments between 11/1/2025-10/31/2026 will be accepted if submitted NO LATER THAN 10/31/2026

PERSONAL INFORMATION

Full Name :

Date Of Birth : _____/_____/_____

Home Address : _____

Phone Number : _____ **E-Mail** : _____

☐ I am an employee

☐ I am a spouse of an employee. Complete Policy Holder Info:

Policy Holder First Name: _____

Policy Holder Last Name: _____

Policy Holder Date of Birth: _____

PHYSICIAN VERIFICATION

This form is to verify an annual physical/well-check visit for a wellness program offered through the patient's employer.

The patient named above has completed a screening during the period of 11/1/2025-10/31/2026 that, at a minimum, included the following:

- Cholesterol Screening
- Glucose Screening
- Blood Pressure Screening
- Body Mass Index (BMI)

☐ Yes

☐ No

I, _____ (Provider Name), conducted an annual physical/well-check office visit and received the paper Health Risk Assessment for the patient listed above. This visit was completed on _____ (Date).

Provider Signature : _____ **Date** : _____

Non-CTU Members Only Respond: Is this appointment being submitted to insurance as preventative or diagnostic?

☐ Preventative

☐ Diagnostic

To receive credit CTU Members MUST, upload this form to your personal dashboard:

- Login at myHealthWorksportal.com
- On your Wellness Checklist, click Annual Physical Verification
- Use "Click Here to Upload a Document for Review" to upload your form
- Choose a file and click ok (any file type permitted: PDF, screenshot, Word doc)
- A "Document Uploaded Successfully" box appears once uploaded
- Please allow 3 business days for processing of forms

Please allow 3 business days for processing of forms

Questions? Call 513-751-1288

INTEGRATED HEALTH 21 | HealthWorks Central Division

Health Risk Assessment

DO NOT SUBMIT THIS FORM TO ANYONE OTHER THAN YOUR HEALTHCARE PROVIDER

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Physician Health Risk Assessment

This Health Risk Assessment should be completed and shared with your physician. Your physician will need to certify completion of this Health Risk Assessment for qualification of wellness premium incentives.

Name	
Date of Birth	Date of HRA Completion

In the past 7 days, how many days did you exercise?	Days
On the days when you exercised, for how long did you exercise (in minutes)?	Minutes

How intense was your typical exercise?

❒ Light (like stretching or slow walking) ❒ Moderate (like brisk walking)
❒ Heavy (like jogging or swimming) ❒ Very heavy (like fast running or stair climbing)
❒ I am currently not exercising

In the last 30 days, have you used tobacco? Smoked Tobacco Product: ❒ Yes❒ No Smokeless Tobacco Product: ❒ Yes ❒ No	If yes to either, would you be interested in a tobacco cessation plan? ❒ Yes ❒ No
In the past 7 days, on how many days did you drink alcohol?	Days

On days when you drank alcohol, how often did you have 3 or more for men, 2 or more for women alcoholic drinks on one occasion?

❒ Never ❒ Once during the week ❒ 2-3 times during the week
❒ More than 3 times during the week

In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.)	Servings
In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day? (1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.)	Servings
In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts,	Servings

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Health Risk Assessment

creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)	
In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume *each day*?	Servings
Do you always fasten your seat belt when you are in the car? ❒ Yes ❒ No	
In the past 2 weeks, how often have you felt down, depressed, or hopeless? ❒ Almost all of the time ❒ Most of the time ❒ Some of the time ❒ Almost never	
In the past 2 weeks, how often have you felt little interest or pleasure in doing things? ❒ Almost all of the time ❒ Most of the time ❒ Some of the time ❒ Almost never	
Have your feelings caused you distress or interfered with your ability to get along socially with family or friends? ❒ Yes ❒ No	
In the past 2 weeks, how often have you felt nervous, anxious, or on edge? ❒ Almost all of the time ❒ Most of the time ❒ Some of the time ❒ Almost never	
In the past 2 weeks, how often were you not able to stop worrying or control you're worrying? ❒ Almost all of the time ❒ Most of the time ❒ Some of the time ❒ Almost never	
How often is stress a problem for you in handling such things as: Your health: ❒ Never or rarely ❒ Sometimes ❒ Often ❒ Always Your finances: ❒ Never or rarely ❒ Sometimes ❒ Often ❒ Always Family/Social: ❒ Never or rarely ❒ Sometimes ❒ Often ❒ Always Work: ❒ Never or rarely ❒ Sometimes ❒ Often ❒ Always	
How often do you get the social and emotional support you need: ❒ Always ❒ Usually ❒ Sometimes ❒ Rarely ❒ Never	
In the past 7 days, how much pain have you felt? ❒ None ❒ Some ❒ A lot	
In general, would you say your health is ❒ Excellent ❒ Very good ❒ Good ❒ Fair ❒ Poor	
In general, would you say your dental health is ❒ Excellent ❒ Very good ❒ Good ❒ Fair ❒ Poor	
On average, how many hours of sleep do you get per night?	Hours
Do you snore or has anyone told you that you snore? ❒ Yes ❒ No	
In the past 7 days, how often have you felt sleepy during the daytime? ❒ Always ❒ Usually ❒ Sometimes ❒ Rarely ❒ Never	

*DO NOT RETURN HEALTH RISK ASSESSMENT TO HEALTHWORKS. ONLY RETURN PHYSICIAN CERTIFICATION FORM.

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