Physician Attestation Form

Patient Name_____ Date of Exam _____

Employee name (if patient is a spouse or domestic partner)

_____

Preventative Care Visit

Place a checkmark next to the type of preventive care visit completed:

- ☐ Annual Well Visit
- ☐ Mammogram
- ☐ Pregnancy Care
- ☐ Colonoscopy
- ☐ Gynecologist Well Visit

Provider Information:
By signing below, I attest that the person named above has had the preventative care visit noted above:

_____ _____
Health Provider Signature Date

_____
Health Provider Please Print

_____
Office Street Address

_____
Office City, State & Zip

_____
Office Phone #

This form is only for new hires and newly eligible plan enrollees who received a qualifying preventative care visit prior to joining Columbus Metropolitan Library's group coverage. The form may be submitted at any time during the plan year. The health premium discount will be applied on the next available pay date following the submission of this form to Payroll & Benefits.

Please return to Payroll & Benefits (payrollbenefits@columbuslibrary.org)