Hello,

Attached is the Medical Waiver/Reasonable Alternative Standard form that was requested. Please have your physician complete the attached form.

**Important Information for you:**

It is **your responsibility** to make sure your doctor completes the waiver and that Marquee Health receives the form no later than the date shown above.

**To avoid confusion:** Please call Marquee Health at 800-882-2109 or email RAS Administrator at ras@mywellportal.com to confirm that we have received the completed form prior to the deadline.

- Once the waiver is received by Marquee Health, it will be reviewed by our medical team for determine qualification. The form will say “Qualified” or “Not Qualified” – you may call our Health Management Team at (800) 882-2109 or email the RAS Administrator to find out the status.

- The medical team will contact you directly if they have any questions regarding your returned waiver.

  This Medical Waiver/Alternative Standard form only covers the **current** wellness program period.

If you have any questions, please let me know and I will be more than happy to help!

**Michelle Sforza**  
Reasonable Alternative Standard Administrator  
Office Phone: 224.534.2918  
Email: msforza@marqueehealth.com

Updated 10/20/2021
HIPAA Medical Waiver/Alternative Standard

Please have your physician complete the information requested below
Return Completed form via
Fax: (847) 264-5544 or Email: ras@mywellportal.com

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Date of Birth:</th>
<th>Member Phone Number:</th>
<th>Member Email:</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______________</td>
<td><em><strong>/</strong></em>/______</td>
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</tbody>
</table>

Return Waiver to Marquee Health
No Later Than: 9/23/2022

Member Name: _______________
Date of Birth: ___/___/______
Member Phone Number: _______________
Member Email: _______________
Company Name: _______________

This individual is participating in an Incentive Based Wellness Program through their employer. The Wellness Program is designed to promote health or prevent disease and offers incentives to individuals that participate and/or who achieve specific health related goals.

The member has indicated that he or she is unable to participate in the wellbeing activities offered, and, therefore, will not otherwise be able to participate in the Wellness Program. Completion of this Physician Verification form will be used (required by HIPAA) to qualify for 100 points in the Wellness Program and is intended to demonstrate that the individual is actively engaged with their Healthcare Provider as a Reasonable Alternative Standard.

Provision of your signature below indicates that this individual is under your care for treatment and promotion of health to prevent disease.

( * ) Required:
* Provider Signature: ____________________________
* Date: ____________________________
* Printed Provider Name: ____________________________
* Office Telephone: ____________________________
* Provider Stamp of Medical Office/Address

Marquee Health Use Only

Qualified [ ] Does Not Meet Qualifications [ ] Deferred Pending More Information [ ]

Health Management Staff Signature: Date: