Physician Attestation Form

INSTRUCTIONS FOR USING THIS FORM:

1. This form should be completed by an employee who has been seen by their doctor within the time frame provided by Eder Financial. Please refer to your program manual for specific details.

2. Please complete the top of the page and then provide the form to your doctor to complete the bottom portion of the page. Please make sure **ALL** fields are completed. Missing values may be considered incomplete for incentive purposes.

3. Please complete this form and return to Eder Financial by:

Fax: 847-742-6336

Email: insurance@eder.org

Mail: Eder Financial
Attn: Benefits Department
1505 Dundee Avenue
Elgin, IL 60120

Questions? Please call 800-746-1505

Commitment to Patient Privacy and Confidentiality:
Eder Financial adheres to the legal duty of patient confidentiality as outlined in HIPAA Security Rule (45CFR Part 160 and Part 164, subparts A and C) for the maintenance and transmission of all patient records. The privacy and confidentiality of our patients are protected under federal HIPAA Regulations, state laws and regulations, and the Ethics Codes of mental health professions. Access of patient records and transmissions by third-party entities, (i.e., employers or family member) is prohibited. Patient information may not be disclosed without the explicit and informed consent of the patient and authorization by their clinician.

REV 10/08/2024

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Please complete the information below and return to Eder Financial

TO BE COMPLETED BY PATIENT:

Your name (please print): _____

Your phone number: _____ Your email: _____

Your date of birth: _____ Last 4 of your SSN: _____

☐ I am an employee of (please note company name): _____

Company division / Location name (if applicable): _____

Authorization

I hereby consent and authorize Eder Financial to receive this physician attestation form for the purpose of my participation in receiving the wellness rates. I understand that my participation is voluntary and give my consent and hereby release Eder Financial from any liability associated with my participation.
No medical information will be shared with Eder Financial. Any results from my exam remain solely between me and my physician, and I should follow up with my physician if any findings/concerns arise a part of this health screening.

Signature _____

TO BE COMPLETED BY A PHYSICIAN:

Note*Please complete all required fields for your patient's wellness program, as missing values may result in incomplete participation.*

I, the Physician, attest to the below:

Date of visit: _____

Physical Exam Completed: Yes ☐ No ☐ If yes, was preventive blood work done? Yes ☐ No ☐

Practice name: _____

Physician's name: _____

Signature: _____

Date: _____

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by: