Physician Attestation Form

INSTRUCTIONS FOR USING THIS FORM:

1. This form should be completed by the employee and their doctor after being evaluated by the doctor, within the time frame specified by Eder Financial, by MARCH 31, 2026. For detailed guidance, please refer to your program manual or contact Eder at insurance@eder.org.

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. If you have questions about what is covered by your plan **before** you have your exam and blood work, consult your Preventative Schedule in your Benefits Guide (or on the MyHighmark app and website). If you have additional questions call Highmark Member Services using the number on the back of your insurance card.

4. 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 ☐ Preventive Blood Work*: Yes ☐ No ☐

Practice name: _____

Physician's name: _____

Signature: _____

Date: _____

*Preventive Blood Work, completed/or none necessary this year. **Please check "Yes" even if no blood work was completed at this year's wellness exam, provided that no preventative blood work is necessary at this time.**

Please complete this form and return to Eder Financial

Fax: **847-742-6336**
Email: insurance@eder.org
Mail: **1505 Dundee Avenue, Elgin, IL 60120**

by: March 31, 2026