Health Partnership Appeal

Medi-Share®

First Name ______________________________ Last Name ____________________________________ CCM ID# _________________

Date of Birth: ______ / ______ / _________
mm dd yyyy

Instructions:

You only need to fill out the sections relevant to your specific metric(s) of appeal.

For BMI, Waist, and blood pressure appeal, a licensed healthcare professional's signature is required to verify measurements. Authorized professionals include MD, DO, PA, RN, RO, firefighter/EMT, CPT, DC, RDN, PT.

Section 1: Appeal for BMI/Waist
Note: This form will not be processed without waist measurement verification. Take a tape measure with you, if necessary.

Height (without shoes): ___________ inches **Weight** (without shoes): ___________ pounds

Estimated weight of clothing during weighing: _______ lbs.

Waist Measurement (at navel; abdomen relaxed) _______ inches **Neck Measurement** (just below larynx): _______ inches

Waist Measurement at narrowest point (Women Only) _______ inches **Hip Measurement** (Women Only): _______ inches

Measure over bare skin from the navel. The tape measure should be snug but not indent the skin. The number that meets the "0" after you have circled you entire waist is your waist measurement. Do not round up/down or use your pants size.

Section 2: Appeal for High Blood Pressure/Hypertension

	1	2	3
Systolic Blood Pressure *	________	________	________
Diastolic Blood Pressure *	________	________	________

**** Tip: we provide a space to allow up to 3 readings, often the first reading can be your highest. wait a few minutes and take 2 additional readings, we will average the 3.***

- ✓ Sit for 5 minutes before you check your blood pressure.
- ✓ Position is important for obtaining accurate results. Place your elbow on a table at the level of your heart for testing and keep your feet uncrossed and touching the floor.

Section 3: Appeal for High Cholesterol

*Submit a full lipid panel (TC,HDL,LDL,TG) lab report from within the last 12 months. No additional signature required.

I affirm that all of the above entries are accurately reported and entered to the best of my knowledge.

Agency of Licensed Healthcare Professional (if applicable): ____

Title of Licensed Healthcare Professional (if applicable): ____

Signature of Licensed Healthcare Professional: ______________________________________ Date: _______________

Signature of Applicant or Member: ____ Date: _______________

Submit the completed form via email to **Health@Medishare.com** or fax to **321-308-7775**.