Tufts Health Plan-Lifespan Diabetes Program 2019 Physician Attestation Form

COMPLETE ALL AREAS BELOW AND DISCUSS WITH YOUR PHYSICIAN. YOU MUST FAX THE COMPLETED FORM IN ORDER FOR YOU TO RECEIVE CREDIT TOWARDS YOUR INCENTIVE, IF APPLICABLE.

PLEASE PRINT ALL INFORMATION CLEARLY.

Member First Name:_____Last Name: _____

Tufts Health Plan Member ID:_____

Date of Birth:_____/_____/_____ Gender: ☐ M or ☐ F

Preferred phone number (including area code):_____-_____- _____

I understand that by submitting this form, I give my consent to Tufts Health Plan to verify the information contained in this form with my physician as listed below.

Member Signature:_____Date:_____/_____/_____

PHYSICIAN TO COMPLETE BELOW LINE:

- Comprehensive Foot Exam
- A1c Test
- Lipid Profile
- Urinary Albumin and eGFR Test
- Dilated Eye Exam

I attest that I have discussed the recommended diabetes tests and screenings and/or results with this patient.

Physician Signature:_____ Date:_____/_____/_____

Physician Printed Name: _____

TUFTS HEALTH PLAN TO COMPLETE BELOW LINE:

Confirmed by:_____ Date:_____/_____/_____

Please submit completed form through secure fax: 855.712.5373

All forms must be submitted by December 15, 2019.

If you have questions regarding the physician statement, you may call the service help desk at 866.201.7919. Representatives are available to help you Monday through Friday, 8 a.m.–9 p.m. ET, excluding national holidays.