

Diabetes Management Rebate (\$100)

Questions about how to complete this form?

Call 801-366-7300 or

Toll free 855-366-7300

Mon-Fri (8 a.m. to 4:30 p.m.)

Return completed form to:

PEHP Healthy Utah
560 East 200 South
Salt Lake City, UT 84102

Or Fax form to:
801-328-7300

Verification: Please have this form completed and signed by your Physician.

Contact Information

NAME (Please Print)		BIRTH DATE	PEHP ID NO.	TODAY'S DATE
EMAIL ADDRESS		PHONE NUMBER	BEST HOURS TO CALL	
PHYSICAL ADDRESS	CITY	ZIP CODE	FAX NUMBER	

Instructions

If you have a diabetes diagnosis, you may take the following steps to earn the Diabetes Management Rebate. Eligible members may earn this rebate once every 12 months. You are not required to submit separate lab results.

- Your rebate form must be signed by your Physician to verify diagnosis of diabetes and completion of yearly medical exams.
- If participating in education session with CDE or dietitian to fulfill rebate requirements, form must also be signed by the CDE or dietitian.
- Mail or fax completed form with signatures to PEHP Healthy Utah. See contact information above.

To qualify for a yearly rebate of \$100, complete all of the following criteria and submit rebate form.

Check boxes upon completion and submit rebate form at one time.

1 Select **ONE** of the following:

- A** Complete an education session with a Dietitian
- B** Participate in PEHP Diabetes and You Online Class
Date completed: _____
- C** Watch 2 PEHP Wellness Webinars of your choice
Webinar Name: _____
Date viewed: _____
Webinar Name: _____
Date viewed: _____

D Participate in one monthly PEHP Wellness Challenge
Challenge Name: _____
Month/Year completed: _____

E Participate in PEHP Workout Warrior for one month
Month/Year completed: _____

Go to www.pehp.org/wellness for information on how to register for the wellness programs listed above in B, C, D, and E. PEHP will verify participation.

- 2** Yearly check for kidney function
- 3** Yearly Diabetic foot exam
- 4** Yearly dilated retinal exam (check box to verify patient is current with retinal exams)
- 5** Prescribed a Statin. If not, explain: _____
- 6** Blood pressure: _____
- 7** HgbA1C: _____

Verification and Signature Required – See Reverse

FOR INTERNAL USE ONLY

Verification _____ Notes _____
Initials _____

Verification

I verify this patient has completed an education session with me.

CERTIFIED DIABETES EDUCATOR (CDE) or DIETITIAN NAME (Please Print)	CDE OR DIETITIAN SIGNATURE	DATE OF SESSION
CDE or DIETITIAN PHONE NUMBER	CDE OR DIETITIAN ADDRESS	

I verify this patient has been diagnosed with diabetes and I verify the accuracy of the information above.

PHYSICIAN'S NAME (Please Print)	PHYSICIAN'S SIGNATURE	DATE
PHYSICIAN'S PHONE NUMBER	PHYSICIAN'S ADDRESS	

6-30-21

Informed Consent & Release

Confidentiality:

I understand the information I have provided in this form is strictly confidential and will not be shared outside of PEHP Health & Benefits, a program of the Utah Retirement Systems ("PEHP"), without my authorization. As a participant of PEHP Healthy Utah, I give permission and understand that my records may be reviewed by PEHP Healthy Utah and PEHP employees. I further understand that I may be contacted by PEHP Healthy Utah or PEHP staff for follow up education or I may be referred to specialized programs. I understand that results on this form and from the online Health Questionnaire will be tracked over time for evaluation purposes. I also understand that PEHP Healthy Utah and PEHP may report results from this form and the online Health Questionnaire(s) to my employer but only as a group, and not as individually identifiable data. Specifically, if my employer participates with the WellRight LLC ("WellRight") wellness tracking system, I voluntarily authorize and request the use and disclosure (including paper, oral, and electronic interchange) by PEHP of my health information provided and described herein into the WellRight tracking tool on my behalf for purposes of my participation in the wellness program.

Assumption of Risk and Release and Waiver:

I consent to voluntarily participate in PEHP Healthy Utah and fully assume any and all risks associated with my participation. I declare that (1) I am free of any known heart or other serious problems; or (2) I have written approval from my physician to participate in PEHP Healthy Utah. In consideration of the information that I will receive from my participation in the program and for other good and valuable consideration, I waive and release all rights and claims against PEHP and the persons administering PEHP Healthy Utah for any and all injuries, ailments, or other consequences that I may suffer from my participation in PEHP Healthy Utah, including but not limited to the biometric screening, online Health Questionnaire, and other activities, programs, and events within PEHP Healthy Utah.

Print Name: _____

Signature: _____ Date: _____