LiveWELL
Work | Eat | Learn | Live
Celebrating 10 Years

2017 CHS LiveWELL Incentive

Know Your Numbers Exception Form

REQUIRED: **Employee ID#**
(Find six-digit ID# by your name on paycheck)

_____ _____ _____
Last Name (print legibly) **First Name** Middle Initial

Birth date: ___ mo/___day/____year **Best phone to reach you:** _____

Work Location & Department_____

I am enrolled in the following CHS LiveWELL Health Plan (circle one): Yes No

Instructions: Ask your Medical Provider or OB/GYN to complete the information below.

Know Your Numbers Exception

(To be completed by your medical provider)

☐ **Pregnancy:** Based on my patient's pregnancy, she is exempt from lab values at this time

☐ **Medical:** Due to the medical history of my patient, he/she is exempt from lab values at this time

Today's Date: _____ mo/_____day/_____year

Provider's Name (**printed)**:_____

Provider's Signature: _____

Phone Number:_____ Practice Name/Location: _____

Deadline: This form must be received by CHS LiveWELL no later than
last day of Benefits Open Enrollment, 2017

Fax the completed form before the deadline to CHS LiveWELL at **704.446.1635** or email to CHSLiveWELLRewards@CarolinasHealthCare.org.