Employee Attestation Form for Physical Examination with Non-Network Provider

Employee Information:

- **Employee Name:** _____
- **Employee ID:** _____
- **University/Campus:** _____
- **Date of Birth:** _____

Provider Information:

- **Provider Name:** _____
- **Provider Phone Number:** _____
- **Date of Physical Examination:** _____

Attestation Statement:

I, the undersigned employee, hereby attest that I have undergone a physical examination with the above-mentioned provider, who is not part of my medical plan's provider network. I understand that this may affect my coverage and benefits under my health plan.

I confirm that the examination was necessary for my health and well-being, and I have chosen to seek care from this provider.

I acknowledge that I am responsible for any costs associated with this examination that may not be covered by my health insurance plan.

Employee Signature: _____ **Date:** _____