



## Employee Attestation Form for Annual 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 Annual Physical Examination:** \_\_\_\_\_

### Attestation Statement:

I, the undersigned employee, hereby attest that I have undergone an annual 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 annual physical examination was necessary for my health and well-being, and I have chosen to seek care from this provider.

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

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_