

**LORAIN COUNTY COMMUNITY COLLEGE  
PREVENTIVE CARE VERIFICATION FORM**

Dear Doctor:

My employer, Lorain County Community College, will provide me with a discount on my medical insurance premiums, if on an annual basis I complete an online health risk assessment and receive some type of age and/or gender specific preventive health care from my physician.

Below for your reference is the list of tests for which the college's medical plans will provide **100% coverage**, if ordered as **routine/preventive care** and not in association with a medical diagnostic code. **You may order any one or more of the following tests as you deem appropriate, for me to be considered as having received some type of preventive health care:**

EKG	Metabolic Panel
CBC	PSA Test
Lipid Profile	Pap Test
Fasting Glucose	Mammogram
Urinalysis	CA 125 Test
Fecal Occult Blood Test	

The college's medical plans also provide coverage at **90%**, subject to the deductible for a routine colonoscopy at age 50 and every 5 years thereafter.

**Please do not indicate what type of preventive health care I received or the results of any routine tests that may be performed. Simply verify that I have received some type of age and/or gender specific preventive health care during the current calendar year, by signing below. Thank you.**

\_\_\_\_\_ has received preventive health care during \_\_\_\_\_  
**Employee/patient** **Year**

\_\_\_\_\_  
**Physician Name (Please print)** **Physician Signature** **Date**

\_\_\_\_\_  
**Employee Name (Please print)** **Employee Signature** **Date**

**Please return this form directly to me and I in turn will forward it to the college.**