

Hello,

Attached is the Medical Waiver/Reasonable Alternative Standard form that was requested. Please have your physician complete the attached form.

**Return the Medical Waiver back to Marquee Health via**

**Fax:** 847-264-5544 or

**Email:** [ras@mywellportal.com](mailto:ras@mywellportal.com)

**No Later than:**

**8/15/2025**

**Important Information for you:**

It is **your responsibility** to make sure your doctor completes the waiver and that Marquee Health receives the form no later than the date shown above.

**To avoid confusion:** Please call Marquee Health at 800-882-2109 or email the RAS Administrator at [ras@mywellportal.com](mailto:ras@mywellportal.com) to **confirm that we have received the completed form prior to the deadline.**

- Once the waiver is received by Marquee Health, it will be reviewed by our medical team to determine qualification. The form will say “Qualified” or “Not Qualified” – you may call our Health Management Team at (800) 882-2109 or email the RAS Administrator to find out the status.
- The medical team will contact you directly if they have any questions regarding your returned waiver.

This Medical Waiver/Alternative Standard form only covers the **current** wellness program period.



Please have your physician complete the information requested below

Return Completed form via

Fax: (847) 264-5544 or Email: [ras@mywellportal.com](mailto:ras@mywellportal.com)

Member Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

Member Phone Number: \_\_\_\_\_

Member Email: \_\_\_\_\_

Company Name: Marquette University

**Return Waiver to Marquee Health 8/15/2025**  
**No Later Than:**

This individual is participating in an Incentive Based Wellness Program through their employer. The Wellness Program is designed to promote health or prevent disease and offers incentives to individuals who participate and/or who achieve specific health related goals.

The member has indicated that they are unable to participate in the wellbeing activities offered, and, therefore, will not otherwise be able to participate in the Wellness Program. Completion of this Physician Verification form will be used (required by HIPAA) to qualify for 200 points in the Wellness Program and is intended to demonstrate that the individual is actively engaged with their Healthcare Provider as a Reasonable Alternative Standard.

Provision of your signature below indicates that this individual is under your care for treatment and promotion of health to prevent disease.

**( \* ) Required:**

\* Provider Signature: \_\_\_\_\_

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

\* Printed Provider Name: \_\_\_\_\_

\* Office Telephone: \_\_\_\_\_

\* Provider Stamp of Medical Office/Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Marquee Health Use Only**

Qualified

Does Not Meet Qualifications

Deferred Pending More Information

Health Management Staff Signature:

Date: