



Doctor's referral form

Health Plan covered programs

Congratulations on joining *CHIP or Weight Watchers®!* Please check a box below, print this form and ask your doctor to sign below so you'll be eligible for **100% reimbursement** from your Adventist Health Employee Health Plan. Minimum attendance/participation levels are required.

CHIP (Complete Health Improvement Program) WeightWatchers®

To our physician partner: Please complete the following form for your patient as a referral to an Adventist Health wellness program/preventive service. Your signature is required for him/her to receive **100% reimbursement** from the Adventist Health Employee Health Plan.

Name of employee: _____

Name of patient (if different from employee) _____

Member ID _____ DOB _____

Diagnoses:	<u>ICD-10 Codes:</u>
1. _____	_____
2. _____	_____

Referring MD or DO

I _____ recommend my patient named above to participate
[Doctor's Printed Full Name]

In this preventive service/wellness program.

Doctor Signature

Date

This message may contain information that is privileged, confidential, and/or protected from disclosure by law. If you are not the intended recipient, or an employee/agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, printing, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately and delete the information from your computer and all other electronic devices. Thank you.