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: ICD-10 Codes:

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