ascend
TO WHOLENESS
HEALTHCARE PLANS

Doctor's Referral Form

PATIENT INFORMATION

TO BE FILLED OUT BY MEMBER					
FIRST (GIVEN) NAME:		MIDDLE INITIAL:		LAST (SURNAME) NAME:	
GROUP#:		MEMBER #:		BIRTHDATE:	

TO BE FILLED BY THE PHYSICIAN

I recommend the patient named above to participate in the following program:

- ☐ **Weight Watchers®**
- ☐ **Complete Health Improvement Program (CHIP)**

Reason for my recommendation:

PROVIDER INFORMATION

PHYSICIAN NAME:		PRACTICE NAME:		PHONE#	
OFFICE ADDRESS:					
CITY:		STATE:		ZIP CODE:	

PLEASE PROVIDE ONE OF THE FOLLOWING:

LICENSE ID:	
TAX ID #:	
NPI:	

Signature **Date**

Administered by:
Adventist Risk Management® Inc.
12501 Old Columbia Pike, Silver Spring, MD 20904

AscendToWholeness.org