

# WELL WISCONSIN

## WELLNESS VISIT VERIFICATION FORM



### FOR THE PROVIDER

Please complete the following sections to document this patient's wellness visit.

Date of Service:		
Patient Name:		
Address:		
Date of Birth:	Phone Number:	
Height:	Weight:	Blood Pressure:
Cholesterol:	Glucose:	

Provider – Print Name

Provider – Date Signed

Provider – Signature

### FOR THE MEMBER

MY PRIMARY CARE PROVIDER \_\_\_\_\_ CLINIC LOCATION \_\_\_\_\_

Please **submit this completed form** to Network Health's Health Promotion Department using one of the methods below.

- ONLINE**
- 1.) Scan this form and save the file to your computer.
  - 2.) Go to networkhealth.com. Click on **Member Sign In** and log into **My Account**.
  - 3.) Click on **Well Wisconsin**, which will bring you to the Well Wisconsin homepage.
  - 4.) From the Well Wisconsin homepage, click on **Submit Activities**.
  - 5.) Complete the online form, attach your file and click **Submit**.
  - 6.) Please allow **10 business days** for your points to appear in **My Account**.

**MAIL TO:** Network Health  
Attn: Health Promotion  
1570 Midway Pl.  
Menasha, WI 54952

**FAX TO:** 920-720-1750

**QUESTIONS:** Contact us via email using the secure contact form found on your Network Health member website, or call us at 920-720-1300 or 800-826-0940.