



Clinical Health Promotion Program Referral Form

Thank you for referring your patient(s) to our Healthy Families Program. This program offers families of members who are ages 7 to 17 assistance with leading a healthy lifestyle and reducing childhood obesity. Our team helps each member by providing education, community resources, and an individualized plan of care over a six-month period. All information contained on this form is strictly confidential and may become part of your patient's record.

Referring physician information			
Referring physician's name:			
Referring physician's phone:			
Referring physician's email:			
Member information			
Member name:			
Referral date:		State MID:	
Member DOB:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/guardian phone:			
Parent/guardian email:			
Reason for referral: * Healthy Families Program: Program offered to children and teens ages 7 to 17. <input type="checkbox"/> Healthy living/nutrition <input type="checkbox"/> Weight management			
Member information			
Member name:			
Referral date:		State MID:	
Member DOB:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/guardian phone:			
Parent/guardian email:			
Reason for referral: * Healthy Families Program: Program offered to children and teens ages 7 to 17. <input type="checkbox"/> Healthy living/nutrition <input type="checkbox"/> Weight management			
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<https://providers.anthem.com/in>

Additional comments
Please email this form to DM-PHP-Provider-Referrals@anthem.com.

For more information about the Clinical Health Promotion Program, visit our website at <https://providers.anthem.com/indiana-provider/patient-care/health-education/disease-management>.