

## 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 physici   | an's email |                         |             |           |          |  |  |
| Member information  |            |                         |             |           |          |  |  |
| Member name:  |            |                         | T =         |           |          |  |  |
| Referral date:  |            |                         | State MID:  |           |          |  |  |
| Member DOB:   |            |                         | Gender:     | □ Male    | □ Female |  |  |
| Parent/guardian p   |            |                         |             |           |          |  |  |
| Parent/guardian e   |            |                         |             |           |          |  |  |
| Reason for referral: *Healthy Families Program: Program offered to children and teens ages 7 to 17. |            |                         |             |           |          |  |  |
| ☐ Healthy living/nutrition ☐ Weight management  |            |                         |             |           |          |  |  |
| Member information  |            |                         |             |           |          |  |  |
| Member name:  |            |                         |             |           |          |  |  |
| Referral date:  |            |                         | State MID:  |           |          |  |  |
| Member DOB:   |            |                         | Gender:     | □ Male    | □ Female |  |  |
| Parent/guardian p   |            |                         |             |           |          |  |  |
| Parent/guardian e   |            |                         |             |           |          |  |  |
| Reason for referral: *Healthy Families Program: Program offered to children and teens ages 7 to 17. |            |                         |             |           |          |  |  |
|   | □ He       | ealthy living/nutrition | ☐ Weight ma | anagement |          |  |  |
| Member information  |            |                         |             |           |          |  |  |
| Member name:  |            |                         | _           |           |          |  |  |
| Referral date:  |            |                         | State MID:  |           |          |  |  |
| Member DOB:   |            |                         | Gender:     | □ Male    | □ Female |  |  |
| Parent/guardian phone:  |            |                         |             |           |          |  |  |
| Parent/guardian e   |            |                         |             |           |          |  |  |
| Reason for referral: *Healthy Families Program: Program offered to children and teens ages 7 to 17. |            |                         |             |           |          |  |  |
| ☐ Healthy living/nutrition ☐ Weight management  |            |                         |             |           |          |  |  |
| Member information Member information   |            |                         |             |           |          |  |  |
| Member name:  |            |                         |             |           |          |  |  |
| Referral date:  |            |                         | State MID:  |           |          |  |  |
| Member DOB:   |            |                         | Gender:     | □ Male    | □ Female |  |  |
| Parent/guardian phone:  |            |                         |             |           |          |  |  |
| Parent/guardian email:  |            |                         |             |           |          |  |  |
| Reason for referral: *Healthy Families Program: Program offered to children and teens ages 7 to 17. |            |                         |             |           |          |  |  |
| ☐ Healthy living/nutrition ☐ Weight management  |            |                         |             |           |          |  |  |

## https://providers.anthem.com/in

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Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

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

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