State of Maryland 2016 Wellness Program Provider Notification Form

Directions: Please bring this form and the results from your online health assessment to your primary care provider (PCP) appointment. After reviewing your results with your PCP, have him/her complete Section II below. Next, submit the form to CareFirst by September 30, 2016.

Section I: Member Information—to be completed by member annually

Last Name	First Name	MI

Date of Birth ___/___/____ mm dd yyyy	Group Number

Member ID Number (please include the alpha prefix and all numbers, i.e. ABC 123 45 6789)

Participant Signature	Date

Section II: Provider Information—to be completed by provider annually

Provider Name

Out-of-network Providers only:
If you are not a participating provider, please include your practice name and address below.

Out-of-network Practice Name	
Practice Address	

City	State	Zip

By signing below, you verify that you have read and reviewed the health assessment results for the participant named above.

Provider Signature	Date

Submission Instructions for Participant

Submit this completed form by logging into *My Account* at **www.carefirst.com/statemd** and uploading your scanned form in jpg, tiff or pdf format. You may also submit the form via:

- Fax to 800-354-8205; or
- Mail to:
  Mail Administrator
  P.O. Box 14116
  Lexington, KY 40512-6116

Please note: to earn your reward, this form must be submitted by September 30, 2016.