State of Maryland 2015 Wellness Program  
Physician Verification 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, 2015.

---

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

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
</table>

**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)

<table>
<thead>
<tr>
<th>Participant Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

---

### 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**

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Provider Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

---

**Submission Instructions for Participant**

Submit this completed form by logging into *My Account* at [www.carefirst.com/statemid](http://www.carefirst.com/statemid) 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, 2015.