WELLNESS VISIT VERIFICATION FORM

network health
WellnessWays

Member Name:			
Date of Service:		Date of Birth:	
Phone Number:		Blood Pressure:	
Height:	Weight:	Fasting Glucose:	
HDL:	LDL:	A1c (optional):	
Tobacco User? ❑ Yes ❑ No		Total Cholesterol:	Total Triglycerides:

Provider – Print Name

Provider – Date Signed

Provider – Signature

FOR THE MEMBER

Please **submit this completed form** using one of the methods below.
(Note: It is the member's responsibility for submitting this completed form to Network Health.)

MAIL: Network Health
Attn: Wellness*Ways*
1570 Midway Pl.
Menasha, WI 54952

FAX: 920-720-1750

EMAIL: **wellnessways@networkhealth.com**

QUESTIONS: Contact us via email using the secure contact form found in your Network Health member portal, email us at **wellnessways@networkhealth.com** or call us at **855-212-5327**.

Member Signature

Date