Wellness Verification Form 2022

Once Completed
Fax to: (806) 791-6341

Full Name: _____

Team Member Number: _____

Section I – Member Information

Blue Cross of Idaho Subscriber ID Number: _____

Team Member Date of Birth (mm/dd/yyyy): _____

Member Signature: _____

Section II – Spouse Information (if the form is being completed for the spouse)

Spouse Name: _____

Spouse Date of Birth (mm/dd/yyyy): _____

Spouse Signature: _____

Section III – Provider Information

Provider Name: _____

Phone Number: _____

Date of Wellness Exam: _____

Provider Signature: _____

Office Use Only

Received _____ Entered _____ Initial _____