Healthy Weight for Life
Referral Form

Instructions:

- Please print clearly.
- Use this form to refer eligible **Alliance children ages 2-18** whose BMI is ≥ **85th** percentile.
- Payment is subject to member eligibility; please verify current eligibility prior to providing services.

Note: Providers receive $25 for an initial referral form and $50 for a follow-up form received 6-12 months later. Payments are per approved form, per linked member, per year.

- **Fill out the referral form completely and make sure that the required data is provided (denoted by asterisks **).**
- Incomplete forms will not be processed.
- Providers must submit all fee-for-service incentive forms within 21 business days from the date of service.
- Please review, reinforce, and modify as necessary the ***"Healthy Weight for Life ~ Rx"*** form and give a copy to the patient.
- Fax this completed referral form to: 1 (877) 793-8504.

Provider name:_____ Practice NPI**: _____ Rendering Provider NPI: _____

Provider phone #: _____ Fax #: _____

Patient name: _____ Alliance ID #**:_____

Patient phone #: _____ Date of birth: _____ Gender: ❒ Male ❒ Female

Does the patient have any of the following comorbidities?

❒ Pre-diabetes ❒ Diabetes ❒ ≥3 BMI percentile point increase within the last 6 months

❒ Sleep apnea ❒ Other risk factors: _____

Body Mass Index (BMI) Assessment:

	Date of Service **	Age at Time of Measurement	Height in Inches **	Weight in Pounds**	(BMI) **Value****	BMI **Percentile**** *Exact BMI Percentile Only*
Initial Assessment						
6-Month Follow-up Reading						
12-Month Follow-up Reading						

* To Calculate BMI data please use the CDC's Child and Teen Calculator: https://nccd.cdc.gov/dnpabmi/Calculator.aspx
** Note: Form must have these minimum data requirements in order to be approved.

The following areas were covered during today's visit: *(Please check all that apply)*

❒ I have counseled the patient regarding **healthy food choices** and portion sizes

❒ I have counseled the patient regarding regular **physical activity**

❒ I have counseled the patient regarding the Alliance's ***Healthy Weight for Life*** program

❒ I have given the patient the "***Healthy Weight for Life ~ Rx***" form

Physician/patient comments: _____

_____

_____

Provider signature: _____ Date signed:_____

Note: Please check the Provider Portal to verify receipt and approval/rejection of this form. If you have questions, please call **1 (800) 700-3874 ext. 5580**.

Healthy Weight for Life ~ Rx

(Receta para un peso sano de por vida)

Nombre del paciente:_____ Fecha: _____

A su doctor le preocupa su salud. Las metas "5210 +" a continuación le pueden ayudar a mejorar su salud día a día.

5 Comer al menos **5** frutas y verduras al día (las frescas o congeladas son las mejores).

2 Limitar el tiempo digital a **2** horas al día – o menos (tele, juegos de video, computadoras).

1 Estar activo por lo menos **1** hora al día (caminar, andar en bicicleta, deportes, etc.).

0 Beber **0** sodas o bebidas dulces al día (como té endulzado, bebidas deportivas, etc.).

+ Duerma lo suficiente.

Tal vez no esté listo para hacer todos los cambios de una sola vez. ¿Qué cambios está listo para hacer ahora y así estar más sano?

5 Comer por los menos _____ frutas y verduras al **día**.

2 Limitar el tiempo de ver pantallas a_____ horas o menos al **día**.

1 Estar activo por lo menos _____ minutos cada **día**.

0 No beber más de_____ sodas o bebidas dulces cada **semana**.

+ Duerma por lo menos_____ horas por **día**.

Firma del padre o tutor: _____ Fecha: _____

Doctor/Health Care Provider Signature: _____ Date: _____

Please give a copy of this form to the patient and keep a copy in the patient's chart.
(Please do not fax this form to the Alliance.)

Si desea saber más sobre el programa **Healthy Weight for Life** de la Alianza, llame a la Línea de Educación de Salud al **1 (800) 700-3874 ext. 5580** o visite www. ccah-alliance.org y haga clic en "Miembros", seleccione la sección Programas de salud.