

**Healthy Behaviors Program:
Weight Management Primary Care Physician (PCP) Verification Form**

This form must be completed and signed by your PCP to show you met your weight loss goal.

Member Information	
Member name:	
Member ID:	
Member DOB:	

We wish you the best of luck meeting your weight loss goal. You should be proud of your commitment to improve your health and wellbeing!

For physician use only:

Please print and sign your name and date next to the appropriate goal achieved by the member. This is necessary in order for the member to receive their incentive. Your cooperation is appreciated.

Goal Reached	Physician printed name	Physician signature	Date
The member achieved 5% weight loss			
The member achieved 10% weight loss			