ascend
TO WHOLENESS
HEALTHCARE PLANS

COMPLETE HEALTH IMPROVEMENT PROGRAMS
CHIP®

Complete Health Improvement Program Attendance Verification

COMPLETE THIS FORM AND SEND IT ALONG WITH YOUR PHYSICIAN'S REFERRAL FORM AND PAYMENT RECEIPTS TO WEBTPA.
(SEE REIMBURSEMENT CHECKLIST FOR ADDRESS INFORMATION)

I, [Name] ______________________________ ,

have attended the [City / State] ______________________________

Complete Health Improvement Program (CHIP) meeting from [Date-MM/DD/YYYY] ________________, until

[Date-MM/DD/YYYY] ________________, and have attended 80% of the sessions for which I am requesting

for reimbursement.

____
Member Name (Print)

____
Department

____
Work Phone [+ Extension #]

____
Member Signature

____
Date

____
CHIP Leader Signature

____
Date

Administered by:
Adventist Risk Management® Inc.
12501 Old Columbia Pike, Silver Spring, MD 20904