



Iowa | Medicaid and Children’s Health Insurance Program

## Clinical Health Promotion Program Referral Form

Thank you for referring your patient(s) to our Healthy Families Program. This program offers families of members who are ages 7 to 17 assistance with leading a healthy lifestyle and reducing childhood obesity. Our team helps each member by providing education, community resources, and an individualized plan of care over a six-month period. All information contained on this form is strictly confidential and may become part of your patient’s record.

|  |   |
|--|---|
| <b>Referring physician information</b>   |   |
| Referring physician’s name:  |   |
| Referring physician’s phone:   |   |
| Referring physician’s email:   |   |
| <b>Member information</b>  |   |
| Member name:   |   |
| Referral date:   | State member ID:  |
| Member DOB:  | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Parent/guardian phone:   |   |
| Parent/guardian email:   |   |
| Reason for referral to Healthy Families Program (program offered to children and teens ages 7 to 17): <input type="checkbox"/> Healthy living/nutrition <input type="checkbox"/> Weight management |   |
| <b>Member information</b>  |   |
| Member name:   |   |
| Referral date:   | State member ID:  |
| Member DOB:  | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Parent/guardian phone:   |   |
| Parent/guardian email:   |   |
| Reason for referral to Healthy Families Program (program offered to children and teens ages 7 to 17): <input type="checkbox"/> Healthy living/nutrition <input type="checkbox"/> Weight management |   |
| <b>Member information</b>  |   |
| Member name:   |   |
| Referral date:   | State member ID:  |
| Member DOB:  | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Parent/guardian phone:   |   |
| Parent/guardian email:   |   |
| Reason for referral to Healthy Families Program (program offered to children and teens ages 7 to 17): <input type="checkbox"/> Healthy living/nutrition <input type="checkbox"/> Weight management |   |

| Member information   |   |
|--|---|
| Member name:   |   |
| Referral date:   | State member ID:  |
| Member DOB:  | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Parent/guardian phone:   |   |
| Parent/guardian email:   |   |
| Reason for referral to Healthy Families Program (program offered to children and teens ages 7 to 17): <input type="checkbox"/> Healthy living/nutrition <input type="checkbox"/> Weight management |   |

| Additional comments   |
|---|
| <br><br><br><br><br><br><br><br><br><br>  |
| <b>Email this form to <a href="mailto:Condition-Care-Provider-Referrals@amerigroup.com">Condition-Care-Provider-Referrals@amerigroup.com</a>.</b> |

For more information about the Clinical Health Promotion Program, visit our website [Disease Management/Population Health | Wellpoint](#).