Wellness Visit Verification

City of Commerce City

Provider Information

Please complete the following information as a verification of the patient's wellness visit.

Date of Visit: _____

Patient Name: _____ **Patient D.O.B.:** _____

Provider Facility/Practice: _____

Print Provider Name: _____

Provider Signature: _____ **Date:** _____

Employee Information

Employee Number: _____ **Employee Name:** _____

Department: _____

Please submit this completed form to Human Resources via interoffice mail, in person, email to c3wellness@c3gov.com.

Incentives will be processed quarterly. The incentives will be added to employee's paychecks when processed. If you complete the wellness visit in the fourth quarter of the calendar year (October through December) the incentive will be processed and paid in the first quarter of the following year.

Commerce CITY