# 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 HR2@c3gov.com, or fax to 303-227-8773.

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