EMPLOYEE HEALTH PLAN
WELLNESS PROGRAM APPLICATION

TOBACCO CESSATION

(Employee Walk-in Clinic or Cleveland Clinic Tier 1 Provider)

Member Name: ________________________________ Medical ID Card Number: ______________________

Employee Name: _______________________________ Employee ID Number__________________________

(must include if dependent is joining)

Address: ___________________________City:__________________State:__________Zip: _________

Home Phone: (_______)_________________ Work Phone: (______)_______________ Ext: ______

Email Address: _____________________________

Check One:

☐ *Employee Walk-in Clinic: ____*

(Treating Provider)

☐ *Cleveland Clinic Tier 1 Program: ____*
(Other/Florida/ Out of Area Members) *(Name of Cleveland Clinic Tier 1 Program/Provider)*

Location/Address: ____

Program Start Date: ______/_____/______

MAIL or FAX COMPLETED FORM WITHIN 10 DAYS OF START DATE TO:

Cleveland Clinic/Akron General
Employee Health Plan
3050 Science Park Drive, AC332B, ATTN: EHP Wellness
Beachwood, OH 44122
Phone: 216.448.2247
Fax: 216.448.2055

AUTHORIZATION FOR RELEASE OF INFORMATION

I am in agreement to participate in the program and provide a cotinine test as verification of participation and tobacco cessation. I understand this information is necessary for payment of the program. This information is completely confidential and will ONLY be used to report program success in the aggregate. NOTE: I understand that payment of program fee by Cleveland Clinic will terminate upon termination of employment, if I cease to be a member of the EHP, or if I do not meet program requirements.

Employee/Participant Signature: ____ Date:____________________