

Wellness Exam/Physical Co-pay Reimbursement Form

Take this form with you to your exam. Complete the information below, have your physician sign the form, and fax to TeamHealth Wellness at 888.422.0106.

Employee Name (print): _____

Email Address: _____

Employee Number (found on paycheck): _____

Co-pay Amount Paid At Visit (include a copy of the receipt): _____

Date of Exam: _____

I certify that the employee named above has received a routine physical exam or a Well-Woman Routine exam.

Physician Signature: _____

Fax the completed form along with a copy of your receipt to the Wellness Program at 888.422.0106. We do not need results of the exam.

