



Physician Consultation Form

Instructions: Participation in the HealthCorridorSM is voluntary. To be eligible to participate, see a physician of your choice, complete this form and mail it to the address below within 60 days following (effective/renewal date). The HealthCorridorSM benefits are described in the schedule of benefits issued by Companion Life Insurance Company. Contact Member Service at 1 (866) 375-1563 with questions.

Part I. Member Information

Last Name:		First Name:		M.I.
Home Address		Home Phone Number		Best to Call AM PM
City/State/Zip		Work Phone Number & Ext		Best to Call AM PM
Member ID Number	Mobile Phone Number		E-Mail	

Part II. Medical Information

1. Provide the date, doctor's name, and location of your physician visit to review the biometric screening assessment information.		
Dr. Name:	City/State	Date:
2. Have you been advised by a physician of a presently existing medical condition(s) or to have tests performed? If so, please provide the physician's name, date of the visit and the conditions and or/tests.		
3. Has a physician prescribed medication for treatment of a condition? If so, please list prescribed medications.		

Part III. Member Representations

I understand that my benefit levels under my employer's group health plan are subject to change dependent upon my voluntary participation in the HealthCorridorSM. I have provided true and complete medical information. Intentional misstatements, misrepresentations or failure to report information are a basis for reducing benefits to the Core Benefit Level.

Member Signature: _____ Date: _____

Mail this completed form to: Creenaght Health Plan
P.O. Box 1330
Rehoboth Beach, DE 19971-0098