Cleveland Clinic

EMPLOYEE HEALTH PLAN TOTAL CARE
WELLNESS PROGRAM APPLICATION

SMOKING CESSATION

(Cleveland Clinic Tier 1 Provider or Tobacco Treatment Clinic)

Member Name: _____ *Medical ID Card Number: EHP*_____

Employee Name: _____ *Employee ID Number*_____

(must include if dependent is joining)

Address: _____*City:*_____*State:*_____*Zip:* _____

*Home Phone: (*_____*)*_____ *Work Phone: (*_____*)*_____ *Ext:* _____

Email Address: _____

Required Program Guidelines: *6 month survey completion,*
12 month survey completion, and
Stopped smoking for 12 months, verified through a urine test

Check One: *Cleveland Clinic Tier 1 Provider* *(Florida EHP Members Only)* *Tobacco Treatment Clinic* *(Cleveland EHP Members Only)*

☐ *Cleveland Clinic Tier 1 Program:* _____
(Name of Cleveland Clinic Tier 1 Program)

Location/Address: _____

☐ *Tobacco Treatment Clinic:* _____
(Cleveland EHP Members Only) *(Tobacco Treatment Clinic Location)*

Program Start Date: _____/_____/_____

MAIL COMPLETED FORM WITHIN 10 DAYS OF START DATE TO:

Cleveland Clinic
Employee Health Plan Total Care
3050 Science Park Dr. AC332b, ATTN: EHP Wellness
Beachwood, OH 44122
Phone: 216-448-0800

Faxes cannot be accepted as an original signature is required.

AUTHORIZATION FOR RELEASE OF INFORMATION

I am in agreement to complete a six month and annual survey from the start date and provide attendance records as required to Cleveland Clinic Employee Health Plan Total Care for verification of participation in the program. 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:*_____