2026 Provider Referral Form

This form must be submitted with your online application to the Weight Management and Diabetes Management Programs. The application link will only be available on our website 11/3/2025-11/17/2025.

Patient Information

Name: _____ **Date of Birth** _____

Height (INCHES) _____**Weight (LBS)** _____**Body Mass Index (BMI)** _____

Blood Pressure _____ **Hemoglobin A1C** _____ **OR Fasting Glucose** _____

Total Cholesterol _____ **LDL Cholesterol** _____ **HDL Cholesterol** _____

Other Comorbid Condition _____

Provider Certification and Signature

By signing below, I certify that I am the treating medical professional for the patient named above and that the medical information provided on this form is true, accurate, and complete to the best of my knowledge as of the date signed.

Print Name _____ **NPI** _____

Signature _____**Date** _____

Participant Consent and Certification

Under penalties of perjury, I declare that I have read the foregoing, and all information provided on this form and in my application is true and correct.
By providing your signature on this form, you consent to share your personal and medical information with the Department of Management Services to participate in the Weight Management Program.
WARNING: Florida law contains severe penalties for fraud. Any person who knowingly and with intent to injure, defraud, or deceive any insurer or state agency files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony. Additionally, whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty is guilty of a misdemeanor.
Aggregate data (your data combined with other participants that does not personally identify you), may be classified by age, gender, or other arrangements, shared with the Florida Legislature for reporting purposes, and used for overall program analysis. Please note that any data shared will not personally identify you or other participants. In addition, your data will not be shared with the other departments or third parties, except as provided in the Department of Management Services Privacy Notice.

Participant Signature

Print Name _____ **People First ID of Employee** _____

Signature _____**Date**_____

Only complete forms will be reviewed. No late forms will be reviewed.
This form cannot be emailed, faxed, or mailed.

Please email questions to the Division of State Group Insurance (DSGI). weightmanagement@dms.fl.gov