Wellness Rewards Program

**PROVIDER VERIFICATION FORM**

Employee Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form provides verification for the Wellness Rewards Program that you received your preventative and wellness service. This form must be completed by your health care provider to receive credit for services received.

**Note: Please Submit Completed Form to Human Resources in a timely manner to receive your credit hour.**

**Services rendered on January 1 – June 30 fiscal year will need to be turned in to HR before July 1 the current calendar year.**

**Services rendered on July 1 – December 31 fiscal year will need to be turned in to HR by December 31 current year.**

Hours will be awarded based on services received during the current calendar year. Completion of Doctor Verification Form does not affect payment for services.

**Health/Dental Care Provider Verification**

On this date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I verify that the employee listed above received the following: (Check all that applies).

**Annual Physical (limit 1 per calendar year) ‐ two hours \_\_\_\_\_\_\_\_**

**Dental Cleaning (limit 2 per calendar year) ‐ one hour \_\_\_\_\_\_\_\_**

**Eye Exam (limit 1 per calendar year) -one hour \_\_\_\_\_\_\_\_**

**Flu Shots ‐ one hour \_\_\_\_\_\_\_\_\_**

**Mammogram (limit 1 per calendar year) – one hour \_\_\_\_\_\_\_\_\_**

**Pap Smears (limit 1 per calendar year) – one hour \_\_\_\_\_\_\_\_\_**

**Prostate Examination – (limit 1 per calendar year) one hour \_\_\_\_\_\_\_\_\_**

**Colonoscopy (limit 1 per calendar year) – two hours \_\_\_\_\_\_\_\_\_**

**Attending Annual Wellness Fair-two hours \_\_\_\_\_\_\_\_\_**

**City of Anderson Recreation Center exercise class that is taught by an Instructor – receive one hour-per month**

***(Please complete the Recreation Verification Form to receive your credit hour).***

***Attention Health Care Provider:*** *In* ***accordance with HIPAA regulations, we are not asking for the results of any of the above tests. We are asking you to simply verify whether he/she has received age and gender specific preventive care during the current calendar year. If yes, then he/she will be eligible to receive Wellness Rewards Hours under our Wellness Program.***

Health Care Provider’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_

Health Care Provider’s Name (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Verification forms must be submitted to HR by each fiscal year to receive Wellness Reward hours.***