



Today's date ___/___/___

Please complete this form with your primary care provider (PCP), specialist, or Women, Infants, and Children (WIC) staff member. We keep the information you list below on record. You must meet eligibility requirements to get the reward. We can't process this reward form if you don't complete this form. You should get your reward in 4 – 6 weeks.

Member information

Member name _____ Member ID # _____ DOB ___/___/___

Member address _____ E-mail address _____

Member phone _____ - _____ - _____ Member alternate phone _____ - _____ - _____

PCP information

PCP name _____

PCP address _____

PCP/Specialist (MD, DO, or RN)/WIC staff member

Please check ONLY one per form.

I confirm that the *Network Health Together* member above:

For kids (age 2)

Completed shots by his or her second birthday: four Dtap, three OPV/IPV, one MMR, four HiB, two hepatitis A, three hepatitis B, one VZV, four PCV, three Rota, flu shot each year, and blood lead screening

Please choose your \$25 gift card CVS Kohl's Toys R Us Wal-Mart

For kids (ages 3 – 9)

Had a yearly checkup on ___/___/___ (date of visit)

Please choose your \$10 gift card CVS Kohl's Toys R Us Wal-Mart

For teens (ages 10 – 17)

Had a yearly checkup on ___/___/___ (date of visit)

Please choose your \$10 gift card AMC Theatres GameStop iTunes Toys R Us

For new mothers

Had a postpartum visit between 21 and 56 days after delivery on ___/___/___ (date of visit)

Visited WIC two times during pregnancy on ___/___/___ and ___/___/___ (dates of visits)

Please choose your \$10 gift card CVS Kohl's Toys R Us Wal-Mart

For members with asthma

Completed an asthma action plan

Please choose your \$10 gift card CVS Kohl's Toys R Us Wal-Mart

For members with diabetes

Completed five routine diabetes screenings in one calendar year: one eye exam, two HbA1C tests, one protein test, and one LDL test

Please choose your \$25 gift card CVS Kohl's Wal-Mart

PCP/Specialist (MD, DO, or RN)/WIC staff member

Please sign below.

Signature _____ Date ___/___/___

Print name _____ Provider ID # _____

Please submit this form to:

Or fax to: 781-393-3530

Network Health

Attn: Customer Service

101 Station Landing, Fourth Floor

Medford, MA 02155

Questions? Call us at 888-257-1985.

Voltee la hoja para la versión en español.



Fecha de hoy ___/___/___

Por favor, complete este formulario con su proveedor de atención primaria (Primary Care Provider, PCP), especialista o personal de WIC. La información que aparece abajo será la que tendremos en nuestros archivos. Los miembros deben cumplir con los requisitos para recibir la recompensa. No podemos procesar recompensas si este formulario está incompleto. Usted recibirá su recompensa(s) dentro de 4-6 semanas.

Información sobre el miembro

Nombre del miembro _____ Número de identificación del miembro _____ Dirección ___/___/___

Member address _____

Teléfono durante el día _____ - _____ - _____ Teléfono alternativo _____ - _____ - _____

Información sobre el proveedor de atención primaria

PCP name _____

Dirección del PCP _____

Para ser completado por el PCP, especialista o personal de WIC

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For members with diabetes

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Please choose your \$25 gift card: CVS Kohl's Wal-Mart

PCP/Specialist (MD, DO, or RN)/WIC staff member

Please sign below.

Signature _____ Date ___/___/___

Print name _____ Provider # _____

Envíe este formulario a:
Network Health
Attn: Customer Service
101 Station Landing, Fourth Floor
Medford, MA 02155

O por fax al: 781-393-3530

¿Tiene preguntas? Llámenos al 888-257-1985.
Turn the page over for English versión.