



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 Extend* 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 Walmart

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 Walmart

For teens (ages 10 – 19)

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

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

For adults (ages 19 and over)

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

Member gets a \$55 health rewards card.

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 Walmart

For members with asthma

Completed an asthma action plan

Please choose your \$10 gift card CVS Kohl's Toys R Us Walmart

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

Member gets a \$25 health rewards card.

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

Please sign below.

Signature _____ Date ____/____/____

Print name _____ Provider ID # _____

Please submit this form to:
Network Health
Attn: Customer Service
101 Station Landing, Fourth Floor
Medford, MA 02155

Or fax to: 781-393-3530

Questions? Call us at 888-257-1985.