Prevention Activity Form

Instructions: Please complete the form below and submit it to Vitality™ with proof of your prevention activity. The proof can include the following:

- **A health care practitioner's signature in Section C of this form**
- **An Explanation of Benefits**
- **A medical record indicating the type and date of service provided or**
- **A copy of your screening results from the doctor's office**

To qualify for Vitality Points™, you must submit your prevention activity within 90 days of it taking place. Each screening can be submitted for points once per policy year.

We encourage you to submit this activity online. Simply log into the Vitality website, navigate to the online submission page, and attach your supporting documentation. Alternatively, you may email your submission to **wellness@powerofvitality.com** or fax it to **877.224.7110**.

Please note, submission via email is not secure until received by Vitality. For your protection, Vitality strongly recommends the use of our online submission option.

Section A: Member's Information

First Name of Member who Completed the Activity:	Last Name of Member who Completed the Activity:
Vitality ID:	Date of Birth:

Section B: Prevention Activity Information

Which screening did you complete? *(check one)*

☐ Colorectal Screening	Date of Screening:	☐ Dental Screening	Date of Screening:	☐ Flu Shot	Date of Screening:
☐ Mammogram	Date of Screening:	☐ Pap Smear	Date of Screening:		

I am including the following as proof of my prevention activity (*check all that apply*):

☐ A practitioner's signature on this form (Section C) ☐ An Explanation of Benefits ☐ A medical record indicating the type and date of service provided ☐ A copy of screening results from my doctor's office

Section C: Physician and/or Facility Information and Certification of Results *(if no other proof of activity is included)*

Health Care Facility Name:	Health Care Facility Address, National Provider ID or CLIA Number:
Health Practitioner's Name:	Phone or Email:

Certification of Results: I certify that I personally conducted this member's procedure as listed above and attest to the accuracy of the information reported herein.

Health Care Practitioner's Signature:	Date of Signature:

Section D: Member's Declaration and Consent

By signing this form, I attest that I completed this prevention activity as listed above and that the information submitted with this request is accurate and complete. I consent and agree that Vitality or any of its representatives has the right to verify and review information to substantiate information and representations herein for the purpose of awarding Vitality Points.

Member's Signature:	Date of Signature:

Questions? Please feel free to contact a Vitality Customer Care representative at **877.224.7117** or **wellness@powerofvitality.com**.
Please note: Vitality complies with HIPAA privacy and security requirements.