Commercial Plans through HealthSource RI
INNOVATION, ECONOMY, COMMUNITY, VALUE, PLUS,
PRINCIPAL, STANDARD, PARTNER, CHOICE, PREMIER and PRIME.

Neighborhood Health Plan OF RHODE ISLAND™

ADULTS (Ages 19 +)

Neighborhood REWARDS Form – Healthy Behaviors

Today's Date ____/____/____

Important information about getting your REWARDS:

- You must be a Neighborhood Health Plan of Rhode Island **Commercial Plan** member when we receive this form.
- If you cannot download the form call Neighborhood Member Services at 1-855-321-9244 and we will mail it to you.
- Please fill out this form with your provider's office. Your provider must be in our network.
- You can request a reward for each service listed that you qualify for (there may be more than one reward).
- You can only request a reward for each behavior once a year or every 12 months.
- You should get your reward 6-8 weeks from when we receive this form.
- Please fill out a separate form for each member.
- **We will not process your request unless you complete this form, have it signed by your provider office and send it to us.**

Member Information (Member receiving service/reward)

Name ______________________________ Member ID #______________
Address ______________________________
City______________________ State ____________ ZIP__________
Phone _______ - _______- _________ Email ______________________
Signature (Parent/Guardian Signature) ______________________________

Provider Office Information

Name ______________________________ Provider NPI #______________

Provider Office to fill out and sign where noted below. Member chooses reward where noted below.

Eligible Members	Provider Office to fill out	Member to choose only one reward
Adults ages 19 +	☐ Had a yearly check-up with PCP ___/___/___ (Date of visit)	$25 gift card to: ☐ Walgreens ☐ Walmart ☐ Stop & Shop
Members with any type of asthma	☐ Completed an asthma action plan	$25 gift card to: ☐ Walgreens ☐ Walmart ☐ Stop & Shop
Members with diabetes	☐ Completed 5 routine diabetes screenings in 1 calendar year: • 2 HbA1c tests • 1 urine test • 1 blood pressure test • 1 foot exam	$25 gift card to: ☐ Walgreens ☐ Walmart ☐ Stop & Shop

Provider Office Signature______________________________
Print name______________________________ Date ________ / ________ /________

Please mail this form to

Neighborhood Health Plan of Rhode Island, Attn: Member Services
910 Douglas Pike
Smithfield, RI 02917
Or fax to: 1-401-709-7090