

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 **ACCESS** or **TRUST** member for 3 months in a row when we receive this form.
- If you cannot download the form call Neighborhood Member Services at 1-800-459-6019 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 below 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 +	<input type="checkbox"/> Had a yearly check-up with PCP ____/____/____ (Date of visit)	\$25 gift card to: <input type="checkbox"/> Walgreens <input type="checkbox"/> Walmart <input type="checkbox"/> Stop & Shop
Members with any type of asthma	<input type="checkbox"/> Completed an asthma action plan ____/____/____ (Date of visit)	\$25 gift card to: <input type="checkbox"/> Walgreens <input type="checkbox"/> Walmart <input type="checkbox"/> Stop & Shop
Members with diabetes	<input type="checkbox"/> Completed 5 routine diabetes screenings in 1 calendar year: <ul style="list-style-type: none"> • 2 HbA1c tests • 1 urine test • 1 blood pressure test • 1 foot exam 	\$25 gift card to: <input type="checkbox"/> Walgreens <input type="checkbox"/> Walmart <input type="checkbox"/> 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