SOLIS HEALTH PLANS

Member Rewards Submission Form

Member Name:	**Date:**
Member ID:	**Date of Birth:**

- Check the box for the healthy activity you completed and fill in the information requested. Some rewards are only eligible during certain time periods. Please make sure the activity you completed is eligible for the current quarter, as rewards can only be claimed during that time.
- **Please note:** This form is only valid for the quarter in which you are submitting your rewards. Any rewards from previous or future quarters will not be accepted.

☐ **A1C Control (<8.0%)** Required 3rd or 4th Quarter - Must be diabetic **$20**
Check your blood sugar level of control.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Adult Access to Primary Care** **$20**
Get to know your PCP & prevent disease(s) early.
Required: ◯ 1st or 2nd Quarter ◯ 3rd or 4th Quarter

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Advanced Care Planning** **$20**
Make your wishes clear to your loved ones with completing your planning documents.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Annual Wellness Visit** **$20**
Get a personal treatment plan based on your health needs every year.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Blood Pressure Control (<140/90)** Required: 3rd or 4th Quarter **$20**
Complete consistent monitoring to reduce your risk of heart disease and stroke.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Breast Cancer Screening** **$20**
Can help find breast cancer early when it is easily treatable.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Colorectal Cancer Screening - Colonoscopy** **$40**
This screening helps to detect colorectal cancer.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Colorectal Cancer Screening - Other Laboratory Colorectal Test** **$20**
This screening might help detect early signs of colorectal cancer.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Diabetic Retinal Exam (DRE) - Must be diabetic** **$40**
Complete an eye exam to check your eyes' overall health to prevent vision loss or blindness.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Fitness Participation** **$20**
Improve your health and your ability to do daily activities by participating in Silver&Fit®.
◯ 1st Quarter ◯ 2nd Quarter ◯ 3rd Quarter ◯ 4th Quarter

☐ **Functional Status Assessment** **$10**
Check your ability to perform daily activities and improve in your weak areas.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Influenza (Flu) Vaccination** Required: 1st or 4th Quarter **$20**
Protect yourself against the flu, also known as influenza virus.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Kidney Health Evaluation Must be diabetic** **$20**
Detects kidney function.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Medication Review** — **$10**
Helps ensure you are on the right medication and there are no worrisome interactions.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Nutritional Education** — **$10**
Helps you better manage your eating habits for a healthier lifestyle.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Pain Assessment** — **$10**
This helps in educating you in pain control options for better wellbeing.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Patient Health Questionnaire (PHQ-9)** — **$20**
Check your mental health and get help if needed.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Pneumococcal Vaccination** — **$20**
Protect yourself against infections like pneumonia.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Risks of Fall Education** — **$20**
Learn to reduce your risk of falling.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

☐ **Smoking Cessation** — **$10**
Prevent smoking-related diseases.

Physician Name:	**Date of Service:**
Phone:	**Physician Signature:**

SOLIS
HEALTH PLANS

Once completed, this form can be sent to Solis Health Plans via:

Mail:
Attn: Member Rewards Department
9250 NW 36 ST, STE. 400
Doral, FL 33178

Email:
member_rewards@solishealthplans.com

If you have any questions regarding your rewards, please contact the Member Rewards Department at **844-732-1688** (TTY: 711).

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