2023 ELECTIVE Preventive **Screening Form**

Preventive Screening Form Instructions

The Trust Claims Administrator will provide a monthly data file to Mobile Health for screenings on or after November 1, 2022, allow four to six weeks. For screenings prior to November 1, 2022, or processed through another health plan, you must submit this form to Mobile Health **no later than December 7, 2023**.

Complete a preventive screening to learn valuable health information and potentially earn contributions to your HSA or HRA.

Register/login to the **Mobile Health Consumer** app or go to: https://www.mobilehealthconsumer.com/web/pages/login.html and view the Rewards section.

You must return your completed form to Mobile Health via fax at 833-421-6742 or via email at forms@mobilehealthconsumer.com. Your confirmation of receipt will show in Mobile health within 10 days.

Ensure your form is accepted by following these guidelines:

- Have your doctor complete and submit the form by **December 7, 2023** to potentially earn HSA/HRA contributions.
- Both you and your doctor need to sign the form. Your doctor must complete the "Provider Instructions" section of the form.
- Use black ink and write legibly.
- All required form fields must be completed. One form per provider.
- Confirm your form was successfully faxed or emailed. **You are responsible** for ensuring you or your physician return this form.
- If you have multiple forms for members of your household, they must be faxed separately.

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2023 ELECTIVE PREVENTIVE SCREENING FORM

PLEASE PRINT CLEARLY AND RETURN ONLY THIS PAGE

All fields are required. If your information is not easily readable, it will not be recorded.

FORM RETURN INSTRUCTIONS

You must return your completed form to Mobile Health via fax at **833-421-6742** or via email at **forms@mobilehealthconsumer.com** **no later than Dec. 7, 2023.**
Your confirmation of receipt will show in Mobile Health within 10 days.

PARTICIPANT COMPLETES AND SIGNS

Participant Authorization and Release

I agree to the release of the information requested below from my provider to Mobile Health to complete preventive care requirements for the ISAS Trust Healthy Choice Wellness Program CORE and ELECTIVE activities.

Name (First): _____ Name (Last): _____

Last four digits of SSN: _____ Date of Birth (MM/DD/YYYY): ____/____/_____

Email Address: _____

Participant Signature: _____

PROVIDER INSTRUCTIONS

For your patient to receive credit for Core and Elective preventive activities, your patient must complete a preventative screening listed below.

Provider Name (printed): _____

Provider Signature: _____

ELECTIVE PREVENTIVE SCREENINGS *(valid dates: 11/1/2022 – 11/30/2023)*

- ☐ HIV Infection Screening - Date of exam _____
- ☐ Hepatitis C Infection Screening - Date of exam _____
- ☐ Osteoporosis Bone Density Screening - Date of exam _____
- ☐ Prostate-Specific Antigen (PSA) Test - Date of exam _____
- ☐ Dental Exam - Date of exam _____
- ☐ Vision Exam - Date of exam _____

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