



Prevention Activity Form

Instructions: Please complete and upload this form in your wellness portal for verification of a preventive activity. Report your activity and attach and upload this form when prompted. Your document will be reviewed within 2 business days of upload.

Note: This form is only necessary if additional verification is not available (i.e. visit summary, receipt for payment, completed vaccination card, etc.) **Important:** All submitted verification items must clearly show date, name, and list activity completed.

Please ensure **all areas of the form are completed**. If your documentation is approved, you will receive points for your activity. If your documentation is denied, the paperclip icon will turn red. **Your documentation can be denied if dates are outside of the plan year or the document is missing appropriate signatures.**

IMPORTANT: All activities must be completed in the 2025 calendar year to be eligible for points.

| Members Information |
|---------------------|
| Partner Name: |

| Prevention Activity (Must be completed in 2025 to be eligible for credit) | |
|---|-----------------|
| Annual Wellness Exam | Date completed: |
| Colorectal Screening | Date completed: |
| Cervical Screening | Date completed: |
| Mammogram | Date completed: |
| Dental Cleaning/Exam | Date completed: |
| Vision Exam | Date completed: |
| Skin Screening (completed by a Dermatologist) | Date completed: |

| Age-Appropriate Vaccination (Must be completed in 2025 to be eligible for credit) | |
|---|-----------------|
| COVID-19 | Date completed: |
| Influenza | Date completed: |
| Zoster recombinant (Shingles) | Date completed: |
| Pneumococcal (Pneumonia) | Date completed: |

| Physician and/or Facility Information and Certification of Results | |
|---|--------------------|
| Facility Name: | Facility Address: |
| Practitioner Name: | Phone or Email: |
| Practitioner's Certification of results: <i>I certify that I personally conducted this member's procedure as listed above and attest to the accuracy of the information reported herein.</i> | |
| Practitioner Signature: | Date of Signature: |

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| Partner's Declaration and Consent: <i>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 Asset or any of its representatives has the right to verify and review information and to substantiate representations herein for the purpose of awarding credit. In addition, you agree falsification of this document may result in disciplinary action, up to and including termination.</i> | |
| Partner Signature: | Date of Signature: |