



ESSENTIAL PLAN

Member Rewards Tracking Form

Member Name:

Member ID Number:

Member Address:

Member Signature:

Email Address:

Phone Number:

	Date of Service	Provider Name	Provider Signature
<input checked="" type="checkbox"/> Annual Comprehensive Visit			
<input checked="" type="checkbox"/> Breast Cancer Screening			
<input checked="" type="checkbox"/> Cervical Cancer			
<input checked="" type="checkbox"/> Chlamydia Screening			
<input checked="" type="checkbox"/> Colorectal Cancer Screening			
<input checked="" type="checkbox"/> Complete Health Risk Assessment			
<input checked="" type="checkbox"/> Diabetes Care: Dilated Eye Exam			
<input checked="" type="checkbox"/> Flu Vaccination			

Please email a scanned copy of this completed form to Rewards@affinityplan.org. You can also fax it to us at 718.794.7821 or mail it to Affinity Health Plan, Attention: QM Department, 1776 Eastchester Road, Bronx, NY 10461.

Certain restrictions apply. For information regarding Affinity's Member Rewards Program, please visit <http://www.affinityplan.org/EP Rewards/>. For more information, call Affinity's Quality Management Department at 718.794.7764 (TTY/TDD: 711) from 8:30AM - 5:00PM, Monday through Friday.



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	Date of Service	Provider Name	Provider Signature
✓ Follow Up After Hospitalization for Mental Illness			
✓ Medication Management for Asthma			
✓ Post Partum Visit (21 to 56 days after delivery)			
✓ Prenatal Care (6+ prenatal visits)			

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