



## MEDICAID

### Member Rewards Tracking Form

**Member Name:**

**Member Signature:**

**Member ID Number:**

**Email Address:**

**Member Address:**

**Phone Number:**

	Date of Service	Provider Name	Provider Signature
<input checked="" type="checkbox"/> Adolescent Wellness Visit			
<input checked="" type="checkbox"/> Breast Cancer Screening			
<input checked="" type="checkbox"/> Complete Affinity's Breathe Easy Asthma Program			
<input checked="" type="checkbox"/> Chlamydia Screening			
<input checked="" type="checkbox"/> Colorectal Cancer Screening			
<input checked="" type="checkbox"/> Comprehensive Diabetes Care: HbA1c Screening + Eye Exam + Nephropathy Screening			

Please email a scanned copy of this completed form to [Rewards@affinityplan.org](mailto: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/MDRewards/>. 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
<input checked="" type="checkbox"/> Follow Up After Hospitalization for Mental Illness			
<input checked="" type="checkbox"/> Medication Management for Asthma			
<input checked="" type="checkbox"/> Post Partum Visit (21 to 56 days after delivery)			
<input checked="" type="checkbox"/> Prenatal Care (6+ prenatal visits)			
<input checked="" type="checkbox"/> Viral Load Suppression (3 monitoring visits & 1 viral load test)			
<input checked="" type="checkbox"/> Well Child Visit - Ages 3-6			
<input checked="" type="checkbox"/> Well Child Visit - 15 months (6+ visits)			

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