PREVENTIVE CARE SUBMISSION FORM

INSTRUCTIONS: PLEASE PRINT IN DARK INK. INITIAL ALL CROSS-OUTS.

- Only submit this form if you are a non-insured member or you have not received credit for your preventive care service after 6 weeks
- The entire form must be filled out and/or appropriate documentation must be included to be eligible for processing:
  - **EOB, MyChart, COVID Vaccine card and other supporting documentation can be accepted in lieu of provider signature**
  - **Documentation must include Name, DOB, and Date of Service**
- Fax or upload the completed form to the portal by the appeal deadline listed in your Program Overview

STEP 1: PARTICIPANT - PLEASE FILL OUT YOUR CONTACT INFORMATION AND SIGNATURE.

NAME			
STREET ADDRESS, PO BOX or APT #			
CITY	STATE	ZIP CODE	DATE OF BIRTH (MM/DD/YEAR) / / MM DD YYYY
EMPLOYER NAME and DIVISION (IF APPLICABLE)			

I hereby attest that I have completed one or more preventive care requirement(s) appropriate for my age, gender, and individual health status.
You MUST list the type of preventive care service you are requesting credit for (i.e., annual physical, mammogram, colonoscopy, etc.).
Refer to your Program Overview for eligible preventive care exams.

SERVICE TYPE: _____ DATE OF SERVICE: _____

SERVICE TYPE: _____ DATE OF SERVICE: _____

SERVICE TYPE: _____ DATE OF SERVICE: _____

OTHER: _____ DATE OF SERVICE: _____

STEP 2: PROVIDER – PLEASE FILL OUT YOUR CONTACT INFORMATION AND SIGNATURE.
PARTICIPANT – THIS SECTION MAY BE SKIPPED IF YOU ARE SUBMITTING APPROPRIATE DOCUMENT.

HEALTHCARE PROVIDER (must be M.D., D.O., P.A. N.P. DDS. or DMD) – **IF SUPPORING DOCUMENTATION IS NOT PROVIDED, THIS FORM CANNOT BE PROCESSED WITHOUT A FULL SIGNATURE, PRINTED NAME, POSITION, PHONE NUMBER, ADDRESS, & DATE.**

PROVIDER SIGNATURE – May not be the same as the participant		LICENSE #
PROVIDER PRINTED NAME	POSITION	PHONE NUMBER
ADDRESS (include city, state and zip)		DATE

STEP 3: FAX OR UPLOAD YOUR COMPLETED FORM AND APPLICABLE DOCUMENTATION TO MEDICAL MUTUAL WELLNESS.

FAX: 833.409.1339. Please print fax confirmation notification and retain for your records.
UPLOAD: Visit your portal to upload your completed form. Follow the step-by-step instructions.

Questions?
Call the Medical Mutual Wellness team toll free at 1-855-553-1006 or send us a message on the portal.