


<b>Member Name:</b>	<b>Date:</b>
<b>Member ID:</b>	<b>Date of Birth:</b>

Please check the box below and provide the date of service if the member has completed the health initiative. **Once completed, please email to [member\\_rewards@solishealthplans.com](mailto:member_rewards@solishealthplans.com).**

	Health Initiative	Date of Service
	<b>Adult Access to Primary Care</b> (1 <sup>st</sup> or 2 <sup>nd</sup> Quarter)	
	<b>Adult Access to Primary Care</b> (3 <sup>rd</sup> or 4 <sup>th</sup> Quarter)	
	<b>Colorectal Cancer Screening</b> <b>Colonoscopy</b>	
	<b>Colorectal Cancer Screening</b> <b>Other Laboratory Colorectal Test</b>	
	<b>Kidney Health Evaluation</b>	
	<b>Nutritional Education</b>	
	<b>A1C Control (&lt;8.0%)</b> (3 <sup>rd</sup> or 4 <sup>th</sup> Quarter - Must be diabetic)	
	<b>Breast Cancer Screening</b>	
	<b>Eye Exam - Diabetic Retinal Exam (DRE)</b>	
	<b>Blood Pressure Control (&lt;140/90)</b> (3 <sup>rd</sup> or 4 <sup>th</sup> Quarter)	
	<b>Risks of Fall Education</b>	
	<b>Fitness Participation</b> (1 <sup>st</sup> Quarter)	
	<b>Fitness Participation</b> (2 <sup>nd</sup> Quarter)	
	<b>Fitness Participation</b> (3 <sup>rd</sup> Quarter)	
	<b>Fitness Participation</b> (4 <sup>th</sup> Quarter)	
	<b>Medication Review</b>	
	<b>Advanced Care Planning</b>	
	<b>Pneumococcal Vaccination</b>	
	<b>Influenza (Flu) Vaccination</b> (Required: 1 <sup>st</sup> or 4 <sup>th</sup> Quarter)	
	<b>Patient Health Questionnaire (PHQ-9)</b>	
	<b>Functional Status Assessment</b>	
	<b>Smoking Cessation</b>	
	<b>Annual Wellness Visit</b>	
	<b>Pain Assessment</b>	

<b>Physician Signature:</b>
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