Tufts Health Plan - Salve Regina University - 2020
Annual Well Visit Form

COMPLETE ALL AREAS BELOW AND DISCUSS WITH YOUR PHYSICIAN. YOU CAN EMAIL, MAIL, OR FAX THE COMPLETED FORM IN ORDER FOR YOU TO RECEIVE CREDIT TOWARDS YOUR INCENTIVE, IF APPLICABLE.

PLEASE PRINT ALL INFORMATION CLEARLY.

Member First Name: _____ Last Name: _____

Tufts Health Plan Member ID: _____

Date of Birth: ____ / ____ / _____ Gender: M or F

Preferred phone number (including area code): _____ - _____ - _____

I understand that by submitting this form, I give my consent to Tufts Health Plan to verify the information contained in this form with my physician as listed below.

Member Signature: _____ Date: ____ / ____ / _____

PHYSICIAN TO COMPLETE BELOW LINE:

I attest that this member has been seen for an annual well visit.

Physician Signature: _____ Date: ____ / ____ / _____

Physician Printed Name: _____

Please submit completed form to:

U.S. Mail:
c/o Tufts Salve Regina University
Wellness Program
Attn: PSS
2100 Rivers Edge Parkway, Suite 500
Atlanta, GA 30328

Fax:
855.712.5373
Attn: Tufts Salve Regina University Wellness Program

Email:
Physician.Statement@PronouncedHealth.com

All forms must be submitted by December 15, 2020.

If you have questions regarding the physician statement, you may call the service help desk at 866.201.7919. Representatives are available to help you Monday - Friday, 8 a.m. – 9 p.m. ET, excluding national holidays.

TUFTS Health Plan