



### Healthy Member Rewards Program

**Eligibility:** Member may receive up to \$75 in gift cards per year for attending their initial and HIV monitoring visits (Section II) and annual reproductive health visit (Section III).

Please complete the below information, including PCP or Specialist signature (Section IV and return to Amida Care via fax (646-786-1837) or mail (248 West 35<sup>th</sup> Street, 7<sup>th</sup> flr., New York, NY 10001).

**Section I Member Information**

Name: \_\_\_\_\_ CIN#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone:(\_\_\_\_\_) \_\_\_\_\_ Other Phone:(\_\_\_\_\_) \_\_\_\_\_

**Section II Primary Care Provider Initial Assessment /Viral Monitoring Visit Information (\$10 gift card)**

PCP Name: \_\_\_\_\_ Site/Facility: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Date of visit: \_\_\_\_\_

Please check all completed activities below.

CD4 Result \_\_\_\_\_  Viral Load Result \_\_\_\_\_

Mental Health Screen \_\_\_\_\_  Substance Abuse Screen \_\_\_\_\_

F/U PCP visit scheduled for \_\_\_\_\_

**Section III Reproductive Health Annual Visit Information (\$25 gift card) 1X/year**

Provider Name: \_\_\_\_\_ Site/Facility: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

GYN Exam done *Date:* \_\_\_\_\_  PAP smear done *Date:* \_\_\_\_\_

STD Screening done *Date:* \_\_\_\_\_

Safety/Prevention Issues, including safe sex, discussed

**Section IV The above mentioned patient has completed their visit as described**

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Please mail or fax (646-786-1837) this form to:*

**Amida Care Health Services @ 248 West 35<sup>th</sup> St. 7<sup>th</sup> flr. New York, NY 10001**