



Member Rewards Activities Form

Name _____ DOB _____ Member ID _____

Please complete this form and return it with any **verification documentation** from your doctor's office using one of these submission methods:

Fax: (714) 551-3831

Mail: Astiva Rewards c/o QI

Email: rewards@astivahealth.com

765 The City Drive South, Suite 200 - Orange, CA 92868

ACTIVITY	ELIGIBILITY	DATE COMPLETED	PROVIDER	LOCATION
Colonoscopy or Stool Occult Blood Test (\$50)				
Breast Cancer Screening (\$50)	Female members			
Diabetic Eye Exam (\$50)	Members with diabetes			
Complete a Post-ER Care Assessment (\$25)	Members visiting ER and are not admitted			
Post-ER follow-up visit with PCP (\$50)	Members who complete follow-up visit with PCP within 7 days Post-ER			

Important Notice: The deadline to earn or submit reward requests for this period is December 31st. Any rewards issued will remain available for use during a grace period ending on March 31st of the following year. All unused funds or credits will be forfeited after this date.

I hereby attest that all the information provided herein is true, accurate, and complete to the best of my knowledge. I understand that Astiva Health, Inc. will rely on this information, and I agree to promptly notify the organization of any material changes. Please have your PCP or authorized staff from PCP's office sign this form upon completion of activities.

Signature _____ Date _____

Print _____