COMPASS HEALTH
WELLNESS & PREVENTION

Annual/Preventative Exam Proof Of Visit

You will receive 20 points for each exam completed.

TELEMEDICINE AND VIRTUAL APPOINTMENTS APPLY.

Patient Information (Please Print)

Name: _____

Physician Information (Please Print)

Physician Office / Name: _____

Office Phone / Address: _____

Date of Visit: _____

Exam:

**Required annually for Wellness Program eligibility*

- ❑ ****Annual Preventative Exam*** Date: _____ **20pts**
  (Physical Performed by Primary Care Physician)
- ❑ ****Blood Screening*** Date: _____ **20pts**
- ❑ **Eye Exam** Date: _____ **20pts**
- ❑ **Colorectal Exam** Date: _____ **20pts**
- ❑ **Dental Exam** Date: _____ **20pts**
- ❑ **Annual OB/GYN Exam (Pap)** Date: _____ **20pts**
- ❑ **Mammogram** Date: _____ **20pts**
- ❑ **Prostate** Date: _____ **20pts**
- ❑ **Other: _____** Date: _____ **20pts**

Healthcare Professional Certification (In lieu of certification, please submit other proof e.g. Invoice/ Bill, Appointment Verification. DO NOT submit private medical information.)

I certify that the patient listed above received the exam indicated on this form on

Date: _____

Signature: _____