COMPASS HEALTH
WELLNESS & PREVENTION

Annual/Preventative Exam Proof Of Visit

You will receive 20 points for each exam completed.

Name: ______________________________ Facility: ______________________________

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

Signature: ______________________________ Date: ______________

Points on this sheet: __________