Good For You!

Proof of Completion Form
Wellness Rewards Program

Participant Name (print): _____

Please have your health provider complete and sign the section for each applicable service. One form may include multiple services, but a separate upload is required for each completed activity in the Good For You Well-Being Portal.

Medical/Health Professional

By signing below, I confirm the participant named above completed the listed service(s), and I am licensed, certified, or otherwise qualified to perform them.

Annual Physical or Well Woman Visit

Provider Name (print): _____Facility:_____

Provider Signature: _____Date of Service: _____

Cervical Cancer Screening

Provider Name (print): _____Facility:_____

Provider Signature: _____Date of Service: _____

Mammogram

Provider Name (print): _____Facility:_____

Provider Signature: _____Date of Service: _____

Colon Cancer Screening

Provider Name (print): _____Facility:_____

Provider Signature: _____Date of Service: _____

Prostate Cancer Screening

Provider Name (print): _____Facility:_____

Provider Signature: _____Date of Service: _____

Flu Shot

Provider Name (print): _____Facility:_____

Provider Signature: _____Date of Service: _____

Dental Exam

Provider Name (print): _____Facility:_____

Provider Signature: _____Date of Service: _____

Vision Exam

Provider Name (print): _____Facility:_____

Provider Signature: _____Date of Service: _____

By signing below, I confirm that I am at least 18 years old, completed the activity(ies) listed during the plan year, and obtained the required provider signatures.

Participant Signature_____Date _____

Once completed, submit this form for the appropriate activities on the Trust Wellness Platform

www.CoreHealthyLife.com/GoodForYou

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