PREVENTIVE CARE SUBMISSION FORM

INSTRUCTIONS: PLEASE PRINT IN DARK INK. INITIAL ALL CROSS-OUTS.

- The entire form and/or appropriate documentation must be filled out to be eligible for processing.
  - EOB or MyChart documentation can be accepted in lieu of provider signature. Must include DOB, Name and Date of Service.
- Form must be completed and received by Medical Mutual Wellness (wellnessappeals@medmutual.com) by the close of your wellness program (deadline date can be found in your Program Guide).

NOTE TO PROVIDER: If you are recommending a different method of testing for a preventive service, please complete step 2b outlining which method you have completed in lieu of the preventive service required. Example: having participant complete thermal imaging in lieu of a mammogram **(PROVIDER SIGNATURE IS REQUIRED FOR ALTERNATIVE METHODS).**

STEP 1: PARTICIPANT - PLEASE FILL OUT YOUR CONTACT INFORMATION AND SIGNATURE.

NAME				EMPLOYEE ID
STREET ADDRESS, PO BOX or APT #				
CITY	STATE	ZIP CODE	DATE OF BIRTH (MM/DD/YEAR) / / MM DD YYYY	
PHONE (WITH AREA CODE)	PARTICIPANT SIGNATURE ^			DATE
EMPLOYER NAME and DIVISION (IF APPLICABLE)	^ SIGNATURE AGREEMENT: By signing, I verify that the information supplied by myself or my representative here is true and complete. I also understand that any person who knowingly and with intent to injure, defraud, or deceive any healthcare carrier, files a statement of claim, or an application containing any false, incomplete or misleading information will be subject to criminal penalties applicable to state laws. By signing this form, I authorize the release of all medical information that Medical Mutual Wellness might need in order to process this alternative.			

STEP 2a: PARTICIPANT - PLEASE COMPLETE THE SECTION BELOW.

I hereby attest that I have completed one or more preventive care requirement(s) appropriate for my age, gender, and individual health status. (Refer to your Program Guide for eligible preventive care exams.)

EXAM TYPE: _____ DATE OF EXAM: _____

EXAM TYPE: _____ DATE OF EXAM: _____

EXAM TYPE: _____ DATE OF EXAM: _____

STEP 2b: PROVIDER - PLEASE OUTLINE ALTERNATIVE METHOD IN LIEU OF PREVENTIVE EXAM, IF APPLICABLE

STEP 3: PROVIDER - PLEASE FILL OUT YOUR CONTACT INFORMATION AND SIGNATURE. PARTICIPANT – THIS SECTION MAY BE SKIPPED IF YOU ARE SUBMITTING APPROPRIATE DOCUMENT

HEALTHCARE PROVIDER (must be M.D., D.O., P.A. N.P. DDS. or DMD) – **IF EOB OR MY CHART IS NOT PROVIDED, PREVENTIVE CARE APPEAL CANNOT BE PROCESSED WITHOUT A FULL SIGNATURE, PRINTED NAME, POSITION, PHONE NUMBER, ADDRESS, & DATE.**

PROVIDER SIGNATURE – May not be the same as the participant		LICENSE #
PROVIDER PRINTED NAME	POSITION	PHONE NUMBER
ADDRESS (include city, state and zip)		DATE

STEP 4: FAX, EMAIL OR MAIL YOUR COMPLETED FORM & APPLICABLE DOCUMENTATION TO MEDICAL MUTUAL WELLNESS.

FAX: ATTN: Appeals & Alternatives Department at 855.201.8803.
Please print fax confirmation notification and retain for your records.

EMAIL: wellnessappeals@medmutual.com

MAIL: Medical Mutual Wellness
ATTN: Appeals and Alternatives Department
20445 Emerald Parkway Dr. SW, Suite 400
Cleveland, OH 44135

Questions? Please contact Medical Mutual Wellness at 855.553.1006