DENTAL BASED TRACKING FORM INSTRUCTIONS

Dental Based Tracking Form: This form recognizes your annual dental visit. The information is used to support a corporate wellness initiative.

STEP 1: PARTICIPANT COMPLETE SECTION 1

A. Print this entire document and fill in the personal information required by Section 1 on the Dental Based Tracking Form.
- Read the Wellness Program Notice and Consent.
- Print legibly using a black pen and ensure that you have completed all fields marked with an * asterisk.
  If information is incomplete or illegible, your form will not be processed.
- Sign the form in the participant (employee/spouse) signature box. **Unsigned forms will not be processed.**

B. Meet with your dentist to have him/her complete **Sections 2 and 3**.

C. Your Unique ID is:
- **Employee Username:** Employer Code + Employee ID
- **Spouse Username:** Employer Code + Employee ID + S

STEP 2: DENTIST COMPLETE SECTIONS 2 and 3

A. Complete all information marked with an * asterisk in Sections 2 and 3.

B. **Dental Information:** The following tests are required to be provided:
- **Required:** Date of Dental Visit

C. **Dental Information:** This section of the form must be completed and signed by your Dentist. **This form will not be processed without a Dentist's signature.** *Signatures by a designated technician will be accepted.*

STEP 3: SUBMIT FORM

A. Participants are responsible for submitting the form by the deadline using **ONE** of the following options:
- **Online:** Visit gotowellnessworks.com, click on Dental Based Tracking Form in your quick links section. Follow the directions provided on that page.
  - **Note:** Online submissions receive immediate confirmation of receipt to email address provided.
- **Fax:** Fax the form to (401) 397-2445. Retain a fax confirmation for your records.
- **Mail the form to:** Preventure | Customer Solutions Department | 2000 Nooseneck Hill Road | Coventry, RI 02816

IMPORTANT NOTES

1. Confirm required fields are completed; make a copy of the form for your records. **Incomplete forms will not be processed.**
2. Participant is responsible to submit this form to Preventure by the submission deadline. **Please do not rely on your Dentist's office to submit the form.**
3. Participant will receive a confirmation email from BCBSRI Wellness Support Team within three (3) business days of fax or mail submission if an email address is provided. Online submissions will receive an immediate confirmation of receipt. Check your spam folder if email notification is not received within three (3) business days, or contact BCBSRI Wellness Support at (401) 385-3964 for assistance.
4. Any incentive credit will be posted to your account within two (2) to four (4) weeks from the time the Dental Based Tracking Form is received.

If you have any questions, please contact BCBSRI Wellness Support at (401) 385-3964.

Dental Based Tracking Form

Incomplete or illegible forms will not be processed. Please print clearly. Items marked with an asterisk * are required. Forms submitted with missing required tests will not be processed.

SECTION 1 - Personal Information (Participant Completes)

Participant First Name * **M.I.** **Participant Last Name***

Employee First Name (if different from Participant) * **M.I.** **Employee Last Name***

Employee's Company Name*

Unique ID* **(see form instruction sheet for your Unique ID)**

Date of Birth* **Primary Phone*** **Secondary Phone**

Email Address ***(Required to receive an email confirmation of receipt of your form)***

Gender*
☐ **Male** ☐ **Female**

Participant Status*
☐ **I am the Employee** ☐ **I am Spouse/Domestic Partner of employee**

Wellness Program Notice and Consent

I authorize the following persons (each, an "Authorized Person") to use or disclose the information obtained on this Physician Screening Form, including my contact information and biometric screening data: Preventure; Blue Cross & Blue Shield of Rhode Island; and/or the subcontractors, consultants, employees, officers, directors, agents and business partners of Preventure, Blue Cross & Blue Shield of Rhode Island and my employer (the "Program Sponsor(s)"). The information obtained on this form may be used or disclosed by the Authorized Persons to provide me with materials that I may find useful, to contact me regarding health-related topics and/or programs, and to manage participation data and incentive campaign(s). I understand that the Authorized Persons are either directly subject to the requirements of HIPAA or are bound by contract to comply with the provisions of HIPAA and are prohibited from re-disclosing my information except as required by law, regulation, court order, subpoena or similar judicial or legal process. In the event of a disclosure required to comply with law, regulation, court order, subpoena, or similar judicial or legal process, I understand that the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. I understand that I may withdraw this Authorization at any time by delivering written notice of my intent to withdraw to Preventure, 2000 Nooseneck Hill Rd., Coventry, RI 02816. I am aware that my withdrawal will not apply to authorized disclosures that were made prior to my withdrawal. I understand that Blue Cross & Blue Shield of Rhode Island and/or the Program Sponsor(s) may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. This authorization will remain valid for one (1) year from the date signed, unless withdrawn in writing. I understand that I have the ability to print a copy of this Authorization. ***By signing below, I acknowledge the Wellness Program Notice and Consent.***

Participant (Employee/Spouse) Signature* **Date***

SECTION 2 - Dental Information (To be completed by your Dentist's office)

Date of Dental Visit*

SECTION 3 – Dentist's Information (To be completed by your Dentist's offce)

Dentist's Name (please print clearly) *

Office Phone Number* **Date*** **Dentist's Signature***