Annual Well Visit Certification

Complete Section 1 of this form, then ask your provider to complete and sign Section 2. Please return your completed form, along with your completed annual well visit reward request form, in one of the provided envelopes.

IMPORTANT: Please print clearly in ink.

Section 1: To be completed by you ...

Member/Patient Name _____

Member ID # _____

Name of Provider _____

Section 2: To be completed by your Provider ...

The purpose of the patient presenting this form to you is to help them follow the USPSTF preventive care guidelines and to qualify them for a member health incentive from Lasso Healthcare. Today's visit, in addition to labs recommended by you to this patient, should form the basis of a personal care plan for the patient to follow in accordance with the USPSTF. If the patient has completed lab work within the last 3 months, or the most recent labs drawn are still considered clinically valid and reliable in your opinion, new labs do not have to be ordered/ drawn.

Date of Service ____ / ____ / ____

Type of Visit ◯ Welcome to Medicare Visit ◯ Medicare Annual Wellness Visit ◯ Routine Physical

Provider Signature _____ Date _____

Credentials _____ NPI _____