ThriveOn
Your Health and Wellness Program

Proof of Exam Form

Franklin County Cooperative employees and spouses/domestic partners can earn incentives by completing preventive health exams. This form can be used to receive credit for your annual physical, preventive screenings, dental exams, and/or vision exams.

To receive credit, you must submit this form if any of the following apply:

- You are ***not enrolled*** in the Franklin County Cooperative Health Plan
- You utilized a different insurance for your preventive exam/screening (i.e. Veterans Affairs)
- You are pregnant and want credit for an OB visit
- It has been more than 60 days since your exam and you have not received credit

Deadlines to complete these forms are as follows, so please plan accordingly.
For the Reduced Deductible incentive:

- The deadline to submit this form for an annual physical with your PCP is **August 31, 2026**.

For a Well-Being Activity incentive:

- The deadline to submit this form for a mammogram, pap smear, colonoscopy, dental exam, or vision exam is **December 31, 2026**.

PROVIDERS:
Please check only the exams that <u>you</u> have performed.

For the Reduced Deductible incentive:

- ☐ I am a primary care provider and the patient listed below completed an annual physical with me between September 1, 2025 and August 31, 2026. Note: Urgent cares, convenience clinics, etc. *do not* qualify.
- ☐ I am an Obstetrician and the patient listed below **is pregnant** and completed a visit with me between September 1, 2025 and August 31, 2026.

For a Well-Being Activity incentive:

- ☐ The patient listed below had a routine *mammogram* with me between January 1, 2026 and December 31, 2026
- ☐ The patient listed below had a routine *pap smear* with me between January 1, 2026 and December 31, 2026
- ☐ The patient listed below had a routine *colonoscopy* with me between January 1, 2026 and December 31, 2026
- ☐ The patient listed below had a routine *dental exam* with me between January 1, 2026 and December 31, 2026
- ☐ The patient listed below had a routine *vision exam* with me between January 1, 2026 and December 31, 2026

Patient Name: _____

Patient DOB: _____

Date of Visit: _____

Provider Name: _____

Practice/Facility Name: _____

Provider Signature: _____

Note: Separate forms will need completed for all exams completed by different providers.

Email this completed form to ThriveOnWellness@OhioHealth.com or fax toll free to (888) 255-0214.

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