Be Well. Live Well.

VNA COMMUNITY HEALTHCARE & HOSPICE

This form is used for proof that you have had of a routine physical, routine eye exam, routine mammogram, routine prostate cancer check or routine colonoscopy.

UHC Plan Year **01/01/2020 – 12/31/2020**

Employee Name	
Date	
UHC Medical Plan you are enrolled in	

I hereby attest to having received a routine physical, routine eye exam, routine mammogram, routine prostate cancer check or routine colonoscopy.

Date of Service	Name of Participant Receiving Service	Service Provider

I certify that the information provided above is true and complete.

Dated: _____ _____

Insured/Employee

Dated: _____ Approved By: _____

Physician/Authorized Representative

HR USE ONLY

Reimbursed on: _____

Amount: _____

Card # _____

Signature for card receipt _____