

Rewards and Reimbursement Form

Please fill out all fields in this form and return via mail or email to the addresses provided below to have funds added to your **OTC Rewards** card.

The OTC Rewards card is for all members of your household and will be mailed to the member listed as the head of household or your parent/guardian. Members can earn a maximum of \$250 in cash and non-cash goods and services each State fiscal year, which runs from July 1 to June 30.

Action completed (Please mark selection clearly)

Well visit (\$25)

Members aged 3 years and older are eligible for this reward once every 12 months. Provider signature required below.

Provider signature _____ Date _____

Health survey (\$25)

Members aged 3 years and older are eligible for this reward once every 12 months. Must complete survey at PCP or pediatrician office visit. Provider signature required below.

Provider signature _____ Date _____

Flu shot (\$10)

Members ages six months and older are eligible for this reward a maximum of two times every 12 calendar months. Provider signature required below.

Provider signature: _____ Date _____

Child lead screening (\$50)

Children ages 11-22 months or 23-35 months are eligible to receive this incentive when completing a lead screening test with a provider. May receive for each age range. Provider signature required below.

Provider signature: _____ Date _____

Hearing aid battery reimbursement (up to \$20)

Members can submit a receipt for a hearing aid battery purchase for reimbursement. The funds for this reimbursement will be mailed to you and not added to an OTC Card. The reimbursement does not count towards the State maximum.

Rewards and Reimbursement Form



Member information (Please print clearly)

Your member ID number (from your WellSense ID card)

Last name		First name		Middle initial
Address		City	State	Zip code
Phone number	Email address			

Provider information (Please print clearly)

Provider office name		Office phone number		
Office address		City	State	Zip code

Please submit this form (and copy of receipt if applicable) by mail or email to

WellSense Health Plan
Attn: Member Incentives
100 City Square, Suite 200
Charlestown, MA 02129

NHHealthyRewards@wellsense.org