2022 Molina Rewards Program
Medicaid (Apple Health) Provider Form
For Children and Adolescents

Provider Instructions

1. Molina Healthcare gives Apple Health members Amazon.com Gift Cards for getting important health screenings. If your patient completed one of the screenings listed below in 2022, please fill out this form LEGIBLY and return to Molina via any of the following ways:
   - **Fax:** Attention Molina Quality Team at (800) 461-3234
   - **Email:** MHW_QI_Interventions@MolinaHealthcare.com
   - **Mail:** Molina Healthcare
Attn: Quality Team
P.O. Box 4004
Bothell, WA 98041-4004
   - **Phone:** Call us at (800) 869-7175, Ext. 141428
2. Please submit claims with appropriate codes after completing each service. If claims are not received, medical records may be requested. **For immunizations, please send a copy of the immunization record along with this form.** All immunization forms without a copy of the immunization record will be denied.
3. The deadline to submit forms for visits completed in 2022 is January 31, 2023.

Member Information

Member's Name: _____ DOB (MM/DD/YYYY): _____

ProviderOne Medicaid ID Number: _____ Molina Member ID Number: _____

Cell Phone Number: _____ Other Phone: _____

Email Address (Required): _____

Email address must be included for the member to obtain their reward(s).

☐ **Check the box if member prefers to receive their rewards in the mail. Please provide a valid mailing address.**

Street Address: _____ Unit: _____

City: _____ State: _____ Zip Code: _____

Provider/Clinician Information

Provider Name: _____ Clinic Location and City: _____

Provider Phone Number: _____ NPI: _____

Provider/Clinician Signature: _____ **Date** (MM/DD/YYYY)**:** _____

30 Month Well-Child Visits (W30): For members who receive six well-child visits before turning 15 months old AND two well-child visits between 15-30 months old *(member may be eligible for a $50 reward).*

Date of Visits for the First 15 Months of Life (MM/DD/YYYY):	
Date of Visit 1: _____	Date of Visit 4: _____
Date of Visit 2: _____	Date of Visit 5: _____
Date of Visit 3: _____	Date of Visit 6: _____
Date of Visits for 15 to 30 Months of Life (MM/DD/YYYY):	
Date of Visit 7: _____	Date of Visit 8: _____

Childhood Immunizations (CIS): For members who receive all required immunizations before turning 2 years old *(member may be eligible for a $50 reward).*				
Please fill in the date that each immunization was administered (MM/DD/YYYY) and send a copy of the immunization record.				
4 DTaP	#1	#2	#3	#4
4 PCV	#1	#2	#3	#4
3 HepB	#1	#2	#3	
3 HiB	#1	#2	#3	
3 IPV	#1	#2	#3	
2 or 3 RV	#1	#2	#3	
2 Flu	#1	#2		
1 HepA	#1			
1 MMR	#1			
1 VZV	#1			
3-11 Year Well-Care Visits (WCV): For members who receive a yearly well-care visit between the ages of 3-11 *(member may be eligible for a $25 reward).*				
Date of Visit (MM/DD/YYYY): _____				
ADHD Medication Follow-Up Visit (ADD-Initiation Phase): For members (ages 6-12) who have a follow-up visit within 30 days of starting their attention-deficit/hyperactivity disorder (ADHD) medication *(member may be eligible for a $25 reward).*				
Date of First ADHD Prescription (MM/DD/YYYY): _____				
Date of Follow-Up Visit (MM/DD/YYYY): _____				
Immunizations for Adolescents (IMA): For members who receive all required immunizations before turning 13 years old *(member may be eligible for a $25 reward).*				
Please fill in the date that each immunization was administered (MM/DD/YYYY) and send a copy of the immunization record.				
1 Meningococcal	#1			
1 Tdap	#1			
2 or 3 HPV	#1	#2	#3	
12-21 Year Well-Care Visits (WCV): For members who receive a yearly well-care visit between the ages of 12-21 *(member may be eligible for a $25 reward).*				
Date of Visit (MM/DD/YYYY): _____				
Chlamydia Screening (CHL): For women ages 16-24 who get an annual chlamydia screening *(member may be eligible for a $25 reward).*				
Date of Screening (MM/DD/YYYY): _____				

For questions, please call (800) 869-7175, ext. 141428, or email MHW_QI_Interventions@MolinaHealthcare.com.