Verification Form – Flu Shot

- **Participants covered under the State of Rhode Island medical plan and eligible for the Rewards for Wellness Program**
- **Participants receiving their flu vaccine at a State-sponsored clinic, their provider's office, or a local pharmacy do not need to complete this form.**
- **The flu vaccine must be administered between January 1st, 2024 and December 31st, 2024.**

This form must be received by: January 15th, 2025.

Verification of Flu Shot:

This purpose of this form is to capture administration of a flu vaccine that is administered at a location other than a State-sponsored flu shot clinic, your provider's office,or a local pharmacy. If you had your flu vaccine at one of these three locations, your credit will process automatically and you do not need to fill out this form.

If you had your flu shot at a location not listed above, please have the vaccine administrator complete this form, and have it emailed to AccountManagementSupport@BCBSRI.org

Section 1- Personal Information. All information is required for processing

First Name _____ Last Name _____

Date of Birth __/__/____ Employee ◯ or Spouse ◯

BCBSRI ID (include the 3 letter prefix) _____

Phone # _____

Email Address _____

I authorize the following persons (each, an "Authorized Person") to use or disclose the information obtained on this Verification Form, including my contact information: Blue Cross & Blue Shield of Rhode Island; and/or the subcontractors, consultants, employees, officers, directors, agents and business partners of Blue Cross & Blue Shield of Rhode Island. The information obtained on this form may be used or disclosed by the Authorized Persons to provide me with materials that I may find useful, to contact me regarding health-related topics and/or programs, and to manage participation data and wellness program incentives. I understand that the Authorized Persons are either directly subject to the requirements of HIPAA or are bound by contract to comply with the provisions of HIPAA and are prohibited from re-disclosing my information except as required by law, regulation, court order, subpoena or similar judicial or legal process. In the event of a disclosure required to comply with law, regulation, court order, subpoena, or similar judicial or legal process, I understand that the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I understand that I may withdraw this Authorization at any time by delivering written notice of my intent to withdraw to Wellness Services, BCBSRI, 500 Exchange St, Providence, RI 02903. I am aware that my withdrawal will not apply to authorized disclosures that were made prior to my withdrawal. I understand that Blue Cross & Blue Shield of Rhode Island and/or the Program Sponsor(s) may not condition treatment, payment, enrollment or eligibility for health insurance benefits on whether I sign this authorization. This authorization will remain valid for 1 year from the date signed, unless withdrawn in writing. I understand that I have the ability to print a copy of this Authorization.

Reasonable alternatives: Your health plan cares about your health. Rewards for participating in this wellness program are available to all those who participate. If you need additional accommodations, we will work with you. For assistance, contact AccountManagementSupport@bcbsri.org.

Participant's Signature _____ Date _____

Signing this form means that the information contained in Section 1 – 2 is accurate and that you agree with Section 1.

Section 2 – Information to be completed by the flu vaccine administrator

Date of flu shot: _____

Location of administration _____

Flu Shot Administrator Printed Name _____

Flu Shot Administrator Signature _____ Phone # _____

Date _____

Need help or have questions? Contact the State of Rhode Island CARE Center at 401-429-2104 or 1-866-987-3705, Monday - Friday 8:00am - 8:00pm, and Saturday 8:00am - Noon.