CHA
Health Plan
www.clearhealthalliance.com/member

Healthy Behaviors

Dear Member:

Thank you for your interest in our Asthma Management Healthy Behaviors Rewards Programs. You're getting this mailing because your case manager or doctor referred you, you referred yourself or you've found this on our website. Your health is important to us. We will support and reward you for taking steps to better your health through our programs.

There are five separate asthma programs your child can join. Each program has different steps to follow to earn a reward. Read the program forms attached for details. You can enroll in one or all five programs if and when you like. It's your choice. When you're ready, just tell your case manager or doctor when you want to enroll in a program.

When you complete each program, you will get a gift card reward!

Want to enroll? Send us your enrollment form. To enroll in another program later, send us this form again. Download a copy from our website, www.clearhealthalliance.com/member.

Then, follow these steps:

1. See your doctor, case manager or pharmacist and follow the plan for each program in which you've enrolled.
2. Fill out the form for each program in which you've enrolled.
    - Mail: CHA Healthy Behaviors Programs,
      9250 W. Flagler St., Ste. 600, Miami, FL 33174-3460
    - Fax: 1-855-329-5289
    - Email: HealthyBehaviors@simplyhealthcareplans.com

Have questions or need help? Call us at 1-844-406-2398 (TTY 711) or email us at HealthyBehaviors@simplyhealthcareplans.com.

Enclosures: Enrollment form
Program forms
Nondiscrimination notice
Get help in another language

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Asthma Management Healthy Behaviors Rewards Programs
Enrollment Form

Please fill out and sign this form to enroll in one or more Asthma Management Healthy Behaviors Rewards Programs. For each program you want to enroll in, place a checkmark in the **Yes, I want to enroll!** table column below.

Yes, I want to enroll!	Program	Description	Gift card
☐	1	Enroll with your case manager	$20
☐	2	See your doctor for an asthma visit	$20
☐	3	Make your Asthma Action Plan	$20
☐	4	Fill all asthma medicines for six months	$50
☐	5	Get your flu shot	$20

Rewards may not be used for gambling, alcohol, tobacco or prescription drugs.

Please tell us how to contact you.

Member name: _____ Date of birth: _____

Member ID #: _____ Cellphone number: _____

Email address: _____

_____

Street address City State ZIP code

Primary parent/caregiver name (if applicable): _____

How would you like us to contact you? (Check all that apply. Contact your case manager to disenroll from these communications at any time.) ☐ Call ☐ Text ☐ Email

Sign your name _____ **Date** _____

Send us this signed form in one of these ways:

- Mail: CHA Healthy Behaviors Programs, 9250 W. Flagler St., Ste. 600, Miami, FL 33174-3460
- Fax: 1-855-329-5289
- Email: HealthyBehaviors@simplyhealthcareplans.com

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Congratulations for taking a step toward better health!

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Asthma Management Healthy Behaviors Rewards Program 1 Form

After you've sent us your signed enrollment form:

1. Talk with your case manager about your asthma. If you qualify, they will enroll you in a plan case management, disease management or clinical program.

2. Sign below. Ask your doctor to sign, too. Also, ask your doctor to send the claim to CHA.

   Sign your name _____ Date _____

   Doctor's signature _____ Date _____

3. Send us this signed form in one of these ways:
   - Mail: CHA Healthy Behaviors Programs,
     9250 W. Flagler St., Ste. 600, Miami, FL 33174-3460
   - Fax: 1-855-329-5289
   - Email: HealthyBehaviors@simplyhealthcareplans.com

Then, get a reward certificate in the mail! You will use it to order your $20 gift card. Rewards may not be used for gambling, alcohol, tobacco or prescription drugs.

Note: Once you are enrolled in this program, you must complete the tasks listed above within 12 months to earn the reward.

We want to stay in touch. Please tell us how to reach you.

Member name: _____ Date of birth: _____

Member ID #: _____ Cellphone number: _____

Email address: _____

_____

Street address City State ZIP code

Primary parent/caregiver name (if applicable): _____

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Asthma Management Healthy Behaviors Rewards Program 2 Form

After you've enrolled in this program:

1. See your doctor for an asthma visit.

2. Sign below. Ask your doctor to sign, too. Also, ask your doctor to send the claim to CHA.

   Sign your name _____ Date _____

   Doctor's signature _____ Date _____

3. Send us this signed form in one of these ways:
   - Mail: CHA Healthy Behaviors Programs,
     9250 W. Flagler St., Ste. 600, Miami, FL 33174-3460
   - Fax: 1-855-329-5289
   - Email: HealthyBehaviors@simplyhealthcareplans.com

Then, get a reward certificate in the mail! You will use it to order your $20 gift card. Rewards may not be used for gambling, alcohol, tobacco or prescription drugs.

Note: Once you're enrolled in this program, you must complete the tasks listed above within 12 months to earn the reward.

We want to stay in touch. Please tell us how to reach you.

Member name: _____ Date of birth: _____

Member ID #: _____ Cellphone number: _____

Email address: _____

_____

Street address City State ZIP code

Primary parent/caregiver name (if applicable): _____

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Healthy Behaviors

Asthma Management Healthy Behaviors Rewards Program 3 Form

After you've enrolled in this program:

1. Create your Asthma Action Plan with your doctor.

2. Sign below. Ask your doctor to sign, too.

   Sign your name _____ Date _____

   Doctor's signature _____ Date _____

3. Send us this signed form in one of these ways:
   - Mail: CHA Healthy Behaviors Programs,
     9250 W. Flagler St., Ste. 600, Miami, FL 33174-3460
   - Fax: 1-855-329-5289
   - Email: HealthyBehaviors@simplyhealthcareplans.com

Then, get a reward certificate in the mail! You will use it to order your $20 gift card. Rewards may not be used for gambling, alcohol, tobacco or prescription drugs.

Note: Once you're enrolled in this program, you must complete the tasks listed above within 12 months to earn the reward.

We want to stay in touch. Please tell us how to reach you.

Member name: _____ Date of birth: _____

Member ID #: _____ Cellphone number: _____

Email address: _____

_____

Street address City State ZIP code

Primary parent/caregiver name (if applicable): _____

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Healthy Behaviors

Asthma Management Healthy Behaviors Rewards Program 4 Form

After you've enrolled in this program:

1. Fill your asthma medications for six months.

2. Sign below. Ask your doctor to sign, too. Also, ask your doctor to send the claim(s) to CHA.

   Sign your name _____ Date _____

   Doctor's signature _____ Date _____

3. Send us this signed form in one of these ways:
   - Mail: CHA Healthy Behaviors Programs,
     9250 W. Flagler St., Ste. 600, Miami, FL 33174-3460
   - Fax: 1-855-329-5289
   - Email: HealthyBehaviors@simplyhealthcareplans.com

Then, get a reward certificate in the mail! You will use it to order your $50 gift card. Rewards may not be used for gambling, alcohol, tobacco or prescription drugs.

Note: Once you're enrolled in this program, you must complete the tasks listed above within 12 months to earn the reward.

We want to stay in touch. Please tell us how to reach you.

Member name: _____ Date of birth: _____

Member ID #: _____ Cellphone number: _____

Email address: _____

_____
Street address City State ZIP code

Primary parent/caregiver name (if applicable): _____

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Healthy Behaviors

Asthma Management Healthy Behaviors Rewards Program 5 Form

After you've enrolled in this program:

1. Get your flu shot.

2. Sign below. Ask your doctor or pharmacist to sign, too. Also, ask your doctor to send the claim to CHA.

   Sign your name _____ Date _____

   Doctor's or pharmacist's signature _____ Date _____

3. Send us this signed form in one of these ways:
   - Mail: CHA Healthy Behaviors Programs,
     9250 W. Flagler St., Ste. 600, Miami, FL 33174-3460
   - Fax: 1-855-329-5289
   - Email: HealthyBehaviors@simplyhealthcareplans.com

Then, get a reward certificate in the mail! You will use it to order your $20 gift card. Rewards may not be used for gambling, alcohol, tobacco or prescription drugs.

Note: Once you're enrolled in this program, you must complete the tasks listed above within 12 months to earn the reward.

We want to stay in touch. Please tell us how to reach you.

Member name: _____ Date of birth: _____

Member ID #: _____ Cellphone number: _____

Email address: _____

_____
Street address City State ZIP code

Primary parent/caregiver name (if applicable): _____