

## APP Personal Attestation Form

### Important Information

This form should be used if you have completed a recommended screening that is not available in existing claim data. You must have your provider complete and sign this form. It will be your responsibility to submit this form to the Anthem Blue Cross and Blue Shield (Anthem) as shown below.

**Submit Completed APP Personal Attestation Forms To:**

Anthem Blue Cross and Blue Shield  
 Attn: Sales Support  
 108 Leigus Road  
 Wallingford, CT 06492

Member Information (Required and must match exactly to what is listed on your Medical Plan ID card.)			
Member Identification Number	Group Number	Employee ID	Dept ID
Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YY)
			/ /
Home Address – Number and Street Name	City	State	Zip Code
Telephone	Email Address		
( ) -			
Member or Parent/Guardian Signature	Date		
X	/ /		
Provider Information (Required)			
Provider Name / Name of Clinic	Provider ID # (If Applicable)	Telephone	Fax
		( ) -	( ) -
Office Address – Number and Street Name	City	State	Zip Code
Provider Signature	Date Signed		

Check Applicable Box on Left for Each Item Being Reported	Completed Date (Month/Year)
<input type="checkbox"/> Preventive Care Exam	
<input type="checkbox"/> Cervical Cancer Screening (ages 21+) One screening required every 3 years	
<input type="checkbox"/> Breast Cancer Screening One screening between the age of 35 and 39; otherwise as recommended by Physician	

	<b>Colorectal Cancer Screening</b> Fecal Occult or FIT annually or Colonoscopy every 10 years beginning at age 50	
	<b>Cholesterol Screening</b> Once every: 5 years (ages 20-29), 3 years (ages 30-39), 2 years (ages 40-49) and every year (ages 50+)	
	<b>PSA Screening</b> One screening after age 50; otherwise as recommended by Physician	

