MENTAL/BEHAVIORAL HEALTH FORM 2026/2027

Please use the Mental/Behavioral Health Form to show your proof of visit to any of the below mental health or behavioral health options.

** Note to Health Care Provider: please do not provide any personal health information (PHI) on this form.*

Employee Name: _____
(Please Print)

Employee No.: _____

Provider's Office / Name: _____

Date of Visit: _____
(Must be between 9/1/2026 – 8/31/2027)

SCREENING TYPE

This **Proof of Visit** confirms that the patient above received the following care within the dates of **9/1/2026 – 8/31/2027:**

☐ **Mental/Behavioral Health provider** ☐ **Spring Health provider**

PROVIDER INFORMATION

I certify that the patient listed above received the exam(s) indicated on this form.

Provider Signature: _____ **Date:** _____

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YOUR JOURNEY STARTS HERE.