

DirectNet Proof of Service

# COLONOSCOPY

Your patient has elected to participate in a medical home plan that requires certain preventive services to receive a reduced insurance premium. Please complete this form and return to DirectNet.

- ❖ Fax: 828-485-4334
- ❖ Email: MemberForms@DirectNetllc.com
- ❖ Mail: 1333 2<sup>nd</sup> Street NE, Suite 200, Hickory, NC 28601
- ❖ Phone: 828-485-4333

Patient Name:	Individual ID Number:
Patient Date of Birth:	Relationship to Insured:

**Screening Colonoscopy**

Date Colonoscopy Completed: \_\_\_\_ \_\_\_\_ \_\_\_\_  
(Month/Day/Year)

Next Recommended Colonoscopy: \_\_\_\_ \_\_\_\_ \_\_\_\_  
(Month/Day/Year)

If colonoscopy is not recommended for this patient, please explain why and for what length of time:

\_\_\_\_\_

Provider Name/Credentials: \_\_\_\_\_ NPI: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Specialty: \_\_\_\_\_

† A Proof of Service Form for a colonoscopy is accepted from a primary care provider that has documentation of a screening colonoscopy. The form is also accepted from a gastroenterology or general surgery provider that performed the colonoscopy.

Signature: \_\_\_\_\_