Proof of Service

# PHYSICAL EXAM

**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 2nd Street NE, Suite 200, Hickory, NC 28601 **Phone:** 828-485-4333


| **Patient Name:** | **Patient Date of Birth:** |
|---|---|

**Annual Physical Completed Date: _____ / _____ / _____**

**Measurements**

Please complete the information below.

| | Value | Date Measured | | Value | Date Measured |
|---|---|---|---|---|---|
| **Height** | | | **Fasting Glucose** (Or HbA1c) | | |
| **Weight** | Lbs. | | **Total Cholesterol** | | |
| **Waist Circumference** | In. | | **Triglycerides** | | |
| **Pulse** | | | **HDL** | | |
| **Blood Pressure** | | | **LDL** | | |

| **PCP Verified Preventive Services** | **Last Completed Date** | **Next Due Date** |
|---|---|---|
| Annual Mammogram (Women 40+ annually) | | |
| Pap Smear (women 20+ every 3 years) | | |
| Colonoscopy (age 50+ and as recommended) | | |

| | |
|---|---|
| **Provider Name/ Credentials:** | **NPI:** |
| **Practice Name:** | **Phone:** |
| **Specialty:** | |
| ***A Proof of Service Form for a physical exam is only accepted from a provider practicing primary care. A **gynecological exam** does **not** meet the requirement of an annual physical exam. Certain Plans may require a medical home provider to complete a physical. Call DirectNet at 828-485-4333 if you have questions.* | |
| **Signature:** | **Date:** |