DirectNet - Proof of Service

DIABETIC EYE 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: Individual ID Number:

Patient Date of Birth: Relationship to Insured:

Diabetic Eye Exam:

Date Diabetic Eye Exam Completed: _____ _____ _____
(Month/Day/Year)

Next Recommended Diabetic Eye Exam: _____ _____ _____
(Month/Day/Year)

If a diabetic eye exam 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 diabetic eye exam is accepted from a primary care provider that has documentation of the diabetic eye exam. The form is also accepted from an ophthalmology, optometry or endocrinology provider that performed the diabetic eye exam.**

Signature: ____

DirectNet
Healthy Together