Diabetic Office Visit / Diabetic Annual Physical

Your patient has elected to participate in a medical home plan that requires certain services to receive a reduced 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:**

Measurements

Diabetic Office Visit Date:

Annual Physical Completed at this visit? ☐YES ☐NO

Last Annual Physical Date:

	Value	Date Measured		Value	Date Measured
Height			**HbA1c**		
Weight			**Total Cholesterol**		
Waist Circumference			**Triglycerides**		
Pulse			**HDL**		
Blood Pressure			**LDL**		

If any of these services are not recommended for this patient, please explain why and for what length of time:

Next Required Diabetic Visit:

☐3 Months ☐4 months ☐ 6 Months *(default)* ☐Other (Specify):_____

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)		

This Proof of Service form is only accepted from primary care, endocrinology and internal medicine providers.

Provider Name/ Credentials:	**NPI:**
Practice Name:	**Phone:**
Specialty:	
Signature:	**Date:**

DirectNet Healthy Together