DirectNet - Proof of Service

MAMMOGRAM

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**:**

Screening Mammogram:

Date Mammogram Completed: _____ _____ _____
(Month/Day/Year)

Next Recommended Mammogram: _____ _____ _____
(Month/Day/Year)

If screening mammogram 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 mammogram is accepted from a primary care provider that has documentation of the mammogram being performed. The form is also accepted from gynecology or radiology providers that performed the mammogram.**

Signature: _____

DirectNet
Healthy Together

Form 2016045