DirectNet - Proof of Service

PAP SMEAR

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**:**

Pap Smear

Date Pap Smear Completed: _____ _____ _____
(Month/Day/Year)

Next Recommended Pap Smear: _____ _____ _____
(Month/Day/Year)

If pap smear 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 pap smear is accepted from a primary care provider that has documentation of a pap smear being performed. The form is also accepted from gynecology providers.**

Signature: _____

DirectNet
Healthy Together