Healthy Indiana Plan Preventive Service Form

Member Name: _____ Date: _____

Physician Name: _____ Member Medicaid ID: _____

Physician Address: _____

Physician Phone: _____ Fax: _____

Dear Physician:

As part of the Healthy Indiana Plan, plus members are eligible to rollover some or all their POWER Account dollars and earn a state match of those rollover dollars at the end of their coverage period if they have received preventive services and have a remaining POWER account balance. Basic HIP members can also earn a State discount of up to 50% if preventive services are present and there are leftover POWER Account dollars. A preliminary review of our records indicates that the member listed above has not received the preventive services required for their rollover this year.

As part of the rollover process members are given the opportunity to provide written documentation from their primary medical provider that the preventive services have been received. Please review the list of preventative services below and indicate whether the member listed above has received all the services necessary to qualify and the date the service**s** were rendered. Please attach a copy of the claim so that MDwise can make sure appropriate payment has been made.

"Well" Preventive Service Age / Gender Requirements:

Preventive Care Services	Male 19-20	Female 19-20	Male 21-34	Female 21-34	Male 35-49	Female 35-49	Male age 50+	Female age 50+
Annual Physical Exam	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Blood Glucose Screening*	X	X	X	**X**	X	**X**	**X**	**X**
Tetanus-Diphtheria Booster	X	**X**	X	**X**	X	**X**	**X**	**X**
Pap Smear*		X		**X**		**X**		**X**
Chlamydia Screening		**X**		Under 25			**X**	
HPV Vaccine**	**X**	**X**		Under 27				
Cholesterol Testing*					**X**	45+	**X**	**X**
Screening Mammogram*								**X**
Colorectal Cancer Screening							**X**	**X**
Flu Shot*	X	X	X	X	**X**	X	**X**	**X**
Pneumococcal vaccine*	X	X	X	X	**X**	X	**X**	**X**
Dental Exam***	X	X	X	X	**X**	X	**X**	**X**
Eye Exam***	X	X	X	X	**X**	X	**X**	**X**

* Annual or as required by specific disease/history conditions
**Males should get the Gardasil HPV vaccine; Females should get either the Gardasil or Cervarix HPV vaccine
*** if coverage is included in your HIP benefit plan

Physician Signature: _____ Physician IHCP Number _____ Date: _____

Note to Physician: **Please check all that apply**
MDwise HIP Member - Please have your doctor complete this form. Once complete, please submit it along with any other documents to: PO Box 44236, Indianapolis, IN 46244-0236. You can also fax the information to: 1-877-822-7190 or in the Indianapolis area 317-829-5530. This form and other documents must be received by MDwise within 60 calendar days of the date on the top of this letter.

HIPM0254 (5/17)