



Healthy Indiana Plan Preventive Service Form

Member Name:					Date:					
Physician Name:				Member	Member Medicaid ID:					
Physician Address:										
Physician Phone:				Fax:	Fax:					
Dear Physician:								_		
As part of the Healthy Indiana rollover dollars at the end of t HIP members can also earn a preliminary review of our record. As part of the rollover process preventive services have been at the little of the rollover.	heir covera State disc rds indicate s members received. Pl	age period if the ount of up to 5 es that the memb are given the op- lease review the	y have received 0% if prevent over listed above poortunity to the list of prevent	ed preventive ser- tive services are te has not receive provide written ntative services	rvices and have present and the ed the prevention documentation below and inc	a remaining POV here are leftover P ye services required a from their prima dicate whether th	WER account be OWER Account of for their rollow ry medical prove e member listed	alance. Basic nt dollars. A ver this year. rider that the d above has		
received all the services nece make sure appropriate paymen			date the serv	ices were rende	ered. Please at	tach a copy of the	e claim so that l	MDwise can		
make sure appropriate paymen "Well" Preventive Service A	ge / Gend Male 19-	made. ler Requiremer					Male age	Female age		
"Well" Preventive Service A Preventive Care Services	ge / Gend Male 19- 20	made. ler Requiremer Female 19-20	nts: Male 21-34	Female 21-34	Male 35-49	Female 35-49	Male age 50+	Female age 50+		
"Well" Preventive Service A Preventive Care Services Annual Physical Exam	ge / Gend Male 19- 20 X	made. ler Requiremer Female 19-20 X	Male 21-34	Female 21-34	Male 35-49	Female 35-49	Male age 50+ X	Female age 50+		
"Well" Preventive Service A Preventive Care Services Annual Physical Exam Blood Glucose Screening*	ge / Gend Male 19- 20 X	ler Requiremer Female 19-20 X X	Male 21-34 X X	Female 21-34 X X	Male 35-49 X X	Female 35-49 X X	Male age 50+ X X	Female age 50+ X X		
"Well" Preventive Service A Preventive Care Services Annual Physical Exam Blood Glucose Screening* Tetanus-Diphtheria Booster	ge / Gend Male 19- 20 X	Female 19-20 X X X	Male 21-34	Female 21-34 X X X	Male 35-49	Female 35-49 X X X	Male age 50+ X	Female age 50+ X X X		
"Well" Preventive Service A Preventive Care Services Annual Physical Exam Blood Glucose Screening* Tetanus-Diphtheria Booster Pap Smear*	ge / Gend Male 19- 20 X	Female 19-20 X X X X X	Male 21-34 X X	Female 21-34 X X X X	Male 35-49 X X	Female 35-49 X X	Male age 50+ X X X	Female age 50+ X X		
"Well" Preventive Service A Preventive Care Services Annual Physical Exam Blood Glucose Screening* Tetanus-Diphtheria Booster Pap Smear* Chlamydia Screening	male 19- 20 X X X	Female 19-20 X X X X X X	Male 21-34 X X	Y X X X X X Y Under 25	Male 35-49 X X	Female 35-49 X X X	Male age 50+ X X	Female age 50+ X X X		
"Well" Preventive Service A Preventive Care Services Annual Physical Exam Blood Glucose Screening* Tetanus-Diphtheria Booster Pap Smear*	ge / Gend Male 19- 20 X	Female 19-20 X X X X X	Male 21-34 X X	Female 21-34 X X X X	Male 35-49 X X	Female 35-49 X X X	Male age 50+ X X X	Female age 50+ X X X		
"Well" Preventive Service A Preventive Care Services Annual Physical Exam Blood Glucose Screening* Tetanus-Diphtheria Booster Pap Smear* Chlamydia Screening HPV Vaccine**	male 19- 20 X X X	Female 19-20 X X X X X X	Male 21-34 X X	Y X X X X X Y Under 25	Male 35-49 X X X	Female 35-49 X X X X	Male age 50+ X X X	Female age 50+ X X X X		
"Well" Preventive Service A Preventive Care Services Annual Physical Exam Blood Glucose Screening* Tetanus-Diphtheria Booster Pap Smear* Chlamydia Screening HPV Vaccine** Cholesterol Testing*	male 19- 20 X X X	Female 19-20 X X X X X X	Male 21-34 X X	Y X X X X X Y Under 25	Male 35-49 X X X	Female 35-49 X X X X	Male age 50+ X X X	Female age 50+ X X X X X		
"Well" Preventive Service A Preventive Care Services Annual Physical Exam Blood Glucose Screening* Tetanus-Diphtheria Booster Pap Smear* Chlamydia Screening HPV Vaccine** Cholesterol Testing* Screening Mammogram*	male 19- 20 X X X	Female 19-20 X X X X X X	Male 21-34 X X	Y X X X X X Y Under 25	Male 35-49 X X X	Female 35-49 X X X X	Male age 50+ X X X X	Female age 50+ X X X X X X		
"Well" Preventive Service A Preventive Care Services Annual Physical Exam Blood Glucose Screening* Tetanus-Diphtheria Booster Pap Smear* Chlamydia Screening HPV Vaccine** Cholesterol Testing* Screening Mammogram* Colorectal Cancer Screening	male 19- 20 X X X X X	rmade. See Requirement	Male 21-34 X X X	Female 21-34 X X X Under 25 Under 27	Male 35-49 X X X X	X	Male age 50+ X X X X X	Female age 50+ X X X X X X X		
"Well" Preventive Service A Preventive Care Services Annual Physical Exam Blood Glucose Screening* Tetanus-Diphtheria Booster Pap Smear* Chlamydia Screening HPV Vaccine** Cholesterol Testing* Screening Mammogram* Colorectal Cancer Screening Flu Shot*	ge / Gend Male 19- 20 X X X X	rmade. See Requirement	Male 21-34 X X X X X	Female 21-34 X X X Under 25 Under 27	Male 35-49 X X X X	X	Male age 50+ X X X X X X	Female age 50+ X X X X X X X X		

Affilial of as required by specific disease/fistory conditions

Physician Signature:	Physician IHCP Number	Date:	
1 Hysician Signature.	1 Hysician III CI I vunibei	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)

^{**}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