Certification of HIP Preventive Services Received

Member ID: _____ Member Full Name: _____

Member Mailing Address: _____

Member City: _____ Member State: _____ Member Zip Code: _____

Member's Preferred Phone #: _____Type: ☐Mobile ☐Home ☐Work ☐Other

The required preventive service(s) for the year are listed below. Please note that applicable services are based on the member's age, gender, and disease/history specific condition(s). **The member needs to have either an annual physical or any of the appropriate age, gender or disease specific services or wellness visit.** Please enter a date of service below for preventive services received.

Service:	Applicable Population:	Date of Service:
Annual Physical	All	
Blood Glucose Screen	All, disease specific	
Tetanus-Diphtheria Booster	All (if applicable)	
Dental Exam	All	
Eye Exam	All	
Cholesterol Testing	Males over age of 35, Females over age of 65, or as required by disease specific condition	
Mammogram	Females over age 50	
Pap Smear	Females between the ages of 21 - 65	
Chlamydia Screen	Females younger than 25	
Colon Cancer Screen	Males and females between ages 50 - 75	
Pneumonia Vaccine	Males and females over the age of 65	
Shingles Vaccine	Males and females over age 60	
Flu Vaccine	All	

Your signature and date on this statement certifies that the above member has completed the appropriate preventive service(s), either the annual physical or other appropriate service.

Practitioner Information

Name: _____ Name of Practice: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Extension: _____

Practitioner NPI #: _____

Signature: _____ Date: _____

Please send the completed form to CareSource by either fax or mail:

Fax Number: 1-844-417-6262

Mailing address: CareSource
Attention: Indiana Member Appeals
P.O. Box 1947
Dayton, OH 45401