



Colonoscopy Incentive Request Form

NAME OF COVERED PHYSICIAN OR EMPLOYEE: _____

HOME ADDRESS: _____

CITY, STATE, ZIP: _____

EMAIL ADDRESS: _____

ANTHEM MEMBER ID (FROM ID CARD): _____

NAME OF COVERED PATIENT: _____

DATE OF SERVICE: _____ PHONE#: _____

SIGNATURE: _____

LOCATION (CHECK APPROPRIATE BOX BELOW):

	Location	Provider Name
<input type="checkbox"/>	Bloomington	Bloomington Endoscopy Center
<input type="checkbox"/>	Evansville	Gastrointestinal Endoscopy Center
<input type="checkbox"/>	Fort Wayne	IU Health Southwest Fort Wayne Ambulatory Surgery Center
<input type="checkbox"/>	Goshen	Goshen Surgery Center
<input type="checkbox"/>	Indianapolis	Northside Gastroenterology Endoscopy Center
<input type="checkbox"/>	Jasper	Jasper Endoscopy Center
<input type="checkbox"/>	Lafayette	Unity Surgical Center
<input type="checkbox"/>	LaPorte	LaPorte Medical Group Surgery
<input type="checkbox"/>	New Albany	Physicians Medical Center
<input type="checkbox"/>	South Bend	The South Bend Clinic

EMAIL TO ismaia@ismanet.org; MAIL to ISMA Insurance Agency, 322 Canal Walk, Indianapolis, IN 46202; or FAX to (317) 261-2238. Questions? Call us at (317) 217-1550.

This incentive program is available to every Medical Practice Consortium subscriber and dependent with coverage. Limited to one reward per subscriber or dependent per calendar year.

Thank you for taking care of your health and for participating in this program!