Health Systems Change Clinic
Referral for Colonoscopy

ENDOSCOPY PROVIDER NOTE: This client has been approved to have a follow-up diagnostic colonoscopy through the Nebraska Women's and Men's Health Programs.

CLINIC REFERRAL REMINDER: Please fax this form ***at time of referral*** to (402) 471-0913.

First Name	Initial	Last Name	Date of Birth
Medical Record #:			

❑ Clinic attesting no financial resources available for coverage

This client has been referred by:

❑Bluestem Health
❑Community Action Partnership of Western Nebraska
❑Charles Drew Health Center
❑Good Neighbor Community Health Center
❑Heartland Health Center
❑Lincoln Medical Education Partnership
❑Midtown Health Center
❑One World Community Health Center
❑Nebraska Urban Indian Health Center

Date of positive FOBT/Fit Test: ____/____/____

This client has been referred for: ❑Colonoscopy

Colonoscopy to be performed:

Endoscopy Provider: _____

Address: _____

Date of Colonoscopy: _____/_____/_____ at ___:___ AM/PM

Billing/Admissions/Patient Registration:
1. This form is only used for referred clients and should only be accepted by contracted facilities.
2. The Endoscopy Center can use the top portion of the form for tracking purposes.
3. Clinic should have received the Nebraska Colon Cancer Screening Program Endoscopy Form.
4. Send claims to: Women's and Men's Health Programs || 301 Centennial Mall South, P.O. Box 94817 || Lincoln, NE 68509-4817

Questions?: Call Joey Labadie at 402-471-6452

Client Name: _____ Date of Birth: _____/_____/_____

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