meridian
A WellCare Company

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Detroit, MI 48226

313-324-3700
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Colorectal Cancer Screening Exclusion Form

Member Name: _____

Member ID#: _____

Date of Birth: _____

This member has had a diagnosis of colorectal cancer or total colectomy.

Date of diagnosis of colorectal cancer: _____

Or

Date of total colectomy: _____

Please attach applicable medical record documentation.

Provider Signature: _____ Date: _____

Please fax the completed form to 1-312-508-7213.

Thank you for your cooperation in this important matter.
Please call the MeridianComplete at **1-855-580-1689** if you have any questions.