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Height: Weight:	★BMI:	HR:	★ BP Result ___/___/____mm hg
Date of last Flu Vaccine ★ ___/___/___		Date of Last BDT (Bone Density Test) ___/___/___ Results: ______________	
Past Medical & Family History:			
Chief Compliant			★ SNP Member: ☐ YES ☐ NO

HEDIS STAR MEASURES

This will be Pre-Populated for our providers.

Physical Examination

System	WNL	Abnormal	System	WNL	Abnormal
HEENT/Oral			Extremities/Pulses		
Neck			Respiratory		
Integumentary			Neurological		
Abdomen			Psychiatric		
Genitalia/Groin/Buttocks			Hematologic/Lymph		
Back			Musculoskeletal		

Review of Systems

The following section is to be used to provide a current assessment of the patient's active condition(s). Each diagnosis must show that it is being **M**onitored, **E**valuated and **A**ssessed. **T**reatment plan must be provided on the last page. If the form is not complete it will be returned.

☐Yes ☐ No	Cataracts	☐RT ☐LT or ☐Both Eyes ☐**Due to Diabetes** Surgery? ☐Yes ☐No (☐ RT ☐ LT or ☐ Both eyes)	☐Active/Stable ☐Progressive
☐Yes ☐No	Retinopathy	**Due to Diabetes**? ☐ Yes ☐ No Due to HTN? ☐ Yes ☐ No Date of last Dilated or Retinal Eye Exam ___/___/___ ☐ Normal ☐ Positive for Retinopathy Eye Provider Name: ______________________________	☐Active/Stable ☐Uncontrolled
☐Yes ☐No	★ Glaucoma Document name of physician who performed glaucoma screen: ______________ ______________	☐ **Due to Diabetes**? ☐ Yes ☐ No All patients 65 years and older without a previous history of glaucoma should be screened. (Glaucoma Screen Reporting Requires Tonometry Results.) High-risk patients include: • Diabetes • Family history of glaucoma • African-American >50 years of age • Hispanic-American >65 years of age Screening Date: _____/_____/____ Screening performed by: Optometrist ☐ Ophthalmologist ☐	☐Active/Stable ☐Progressive
Cardiovascular		☐ Chest Pain ☐ Dyspnea ☐ Palpitation ☐ Syncope ☐ Previous MI ☐ Diaphoresis ☐Reynaud's ☐ Claudication ☐Cool Extremities ☐ Cyanosis ☐ Edema ☐ Erythema ☐ Pain in Extremities	
☐ Yes ☐ No	Heart Failure	☐ CHF right or left ventricle failure ☐ Left HF ☐ Systolic HF ☐ Diastolic HF ☐Unspecified HF ☐Combined Sysolic/Diastolic HF Last BNP Result: _______ Last Echo: ________ Ejection Fraction %:_____ Exam Details	☐Active/Stable ☐Progressive ☐Resolved
☐Yes ☐No	CAD/ASHD Old MI	☐Effecting Native Vessel ☐Affecting BP-Graft (type of graft) Exam Details: ______________________ Date of Event: __________	☐Active/Stable ☐Resolved
☐Yes ☐No	Arrhythmia	Type: Date and Result of Last EKG: Pacemaker Y/N Reason:	☐Active/Stable ☐Uncontrolled ☐Resolved
☐Yes ☐No	Sick Sinus Heart Block Angina	☐Tachycardia-Bradycardia Type: Type: Exam Details:	☐Active/Stable ☐Acute ☐Uncontrolled ☐Resolved

Pre-Populated Member Information

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:	MD ☐ DO ☐ NP ☐ PA ☐			DOS:	______/______/__________

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☐Yes ☐No	HTN	☐ Benign ☐Malignant ☐ Hypertensive Heart Disease ☐with CHF/HF ☐Hypertensive CKD ☐ Hypertensive Heart & CKD ___________ Date of LDL-C ___ / ___ / _____ Results___________________ Name of provider managing HTN: ______________________________	☐Active/Stable ☐Uncontrolled
☐Yes ☐No	PAD/PVD	☐**Due To Diabetes** or ☐Due to Atherosclerosis or ☐Both Diabetes & Atherosclerosis ☐With Claudication ____ ☐Pain at Rest ___ ☐Ulcers & Location ☐ Gangrene-Location ____ Other:____________________ **Date and result of last ABI**:____________________________________ Exam Details:	☐Active/Stable ☐Progressive
☐Yes ☐No	Amputation	Type and Location: ______________________________ Exam Details:	☐Healed ☐Not Healed
☐Yes ☐No	DVT or PE	☐ Acute ☐Chronic ☐History of DVT/PE_________ ☐Greenfield Filter Exam Details:	☐Active/Stable ☐Progressive
☐Yes ☐No	Aneurysm	Location:___________ Size:________________ Last U/S:____________ Exam Details:	☐Active ☐Resolved
Respiratory		☐Cough ☐Dyspnea ☐TB Exposure ☐Hemoptysis ☐ +PPD (Date:_________) ☐Pleuritic Pain ☐Snoring ☐Frequent URIs ☐Wheezing ☐ Sputum Production (Color:_____________ Frequency:________________)	
☐Yes ☐No	Lung Disease	☐COPD ☐Emphysema ☐Chronic Bronchitis ☐Asthma ☐Pulmonary HTN ☐Fibrosis of Lung ☐Smoker Cough Date of Last Spirometry : ________________ FEV1% (FEV1/FVC): __________ Exam Details:	☐Active/Stable ☐Acute Exacerb ☐End Stage
☐Yes ☐No	Chronic Resp. Failure/Hypoxia	☐Oxygen Dependence ☐Current Tracheotomy Status ☐Reduce Size ☐Hypoxic_____% Oxygen Oxygen Use: ☐Yes ☐No Exam Details:	☐Active/Stable ☐Progressive ☐End Stage
Gastrointestinal		☐Abdominal Mass ☐Abdominal Pain ☐Anorexia ☐Hematemesis ☐Hematochezia ☐Constipation ☐Diarrhea ☐Dysphagia ☐Jaundice ☐Nausea☐Enteral Feeding Tube ★ **Colonoscopy** ☐ Yes ☐ No Date:______________ Details: ★ **Sigmoidoscopy** ☐ Yes ☐ No Date:______________ Details: ★ **FOBT** ☐ Yes ☐ No Date:______________ Details:	**HEDIS STAR MEASURES**
☐Yes ☐No	Cirrhosis	Etiology (if known): Exam Details:	☐Active ☐Resolved
☐Yes ☐No	End Stage Liver Disease	Etiology (if known): Exam Details:	☐Active ☐Resolved
☐Yes ☐No	Hepatitis	Type: ☐A ☐B ☐C ☐Alcoholic ☐Drug Induced ☐Autoimmune ☐Acute ☐Chronic	☐Active/Stable ☐Progressive
☐Yes ☐No	Pancreatic Disease	☐HX of Pancreas Transplant ☐Chronic Pancreatitis Exam Details:	☐Active ☐Resolved
☐Yes ☐No	IBS	Type: ☐Ulcerative Colitis ☐Crohn's Exam Details:	☐Active/Stable ☐Resolved
☐Yes ☐No	CKD	Type: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ End Stage ☐ Unknown **Due to Diabetes**? ☐Yes ☐No On Chronic Dialysis? ☐Yes ☐No Kidney Transplant? ☐Yes ☐No (If yes, which Kidney: ☐ RT ☐ LT) **Date and result of last eGFR**: ______________________________________	☐Active/Stable ☐Progressive ☐Resolved
Musculoskeletal		☐Ambulation/Gait Changes ☐Back Pain ☐Myalgias ☐Join/bone Symptom ☐Rheumatologic Manifestations	

Pre-Populated Member Information

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:	MD ☐ DO ☐ NP ☐ PA ☐			DOS:	______/______/__________

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☐Yes ☐No	Arthritis	Has patient been prescribed drugs to prevent Osteoporosis? Y__N__ Name(s) of Bisphosphonate or Hormone Meds Prescribed: ______________________________ ______________________________ ☐Osteoarthritis ☐Rheumatoid Arthritis Other:________________ Has patient been prescribed Anti Rheumatic Drug? Y__N__ Name(s) of DMARD prescribed: ______________________________	☐Active/Stable ☐Uncontrolled ☐Resolved
Skin/Breast		Skin: ☐Rash ☐Skin Lesion ☐Nail Changes ☐Hair Loss Breast: ☐Nipple Discharge ☐Breast Lumps ☐Breast Pain	
☐Yes ☐No	Skin Ulcer	Type and Location:___________________________________ If Pressure Ulcer: Stage:__________________ ☐Gangrene Y☐ N☐ Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
Women Only	Breast Cancer Screening	Date of last Mamogram: ___/____/______ Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
Neurology		☐Aphasia ☐Dysarthia ☐Focal Weakness ☐Gait Disturbance ☐Headache ☐Incoordination ☐Progressed Cognitive Impairment ☐Incontinence ☐Involuntary Movement ☐Lightheadedness/Dizziness ☐Loss of Consciousness ☐Paresthesias ☐Seizures ☐Tingling to Extremities ☐Tremors ☐Vertigo ☐Numbness, weakness	
☐Yes ☐No	Seizures Multiple Sclerosis	Exam Details: Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
☐Yes ☐No	Parkinsons's Disease	Exam Details :	☐Active/Stable ☐Acute Exacerb
☐Yes ☐No	Neuropathy	**Due to Diabetes**? ☐Yes ☐No ☐Date of last monofilament with result: Location & Etiology: Exam Details:	☐Active/Stable ☐Resolved
☐Yes ☐No	Dementia	Type: ☐Alzheimer's ☐Vascular ☐Senile ☐Last MMSE results if known: ☐Agitation _Delirium ☐ Depressed Mood Exam Details:	☐Early Stage ☐Middle Stage ☐End Stage
Psychology		☐Anger ☐Anxiety ☐Delusions ☐Depression ☐Euphoria ☐Fearfulness ☐Irritability ☐Obsession ☐Paranoia ☐Psychotic Behavior ☐Sleep Disturbance ☐Suicidal Ideations ☐Memory Loss ☐Social Withdraw ☐History of Antipsychotic Drug Use ☐Mood Change ☐Impulsive Behavior ☐Impaired Abstract ☐Personality Change	
☐Yes ☐No	Major Depression	Type: ☐Mild ☐Moderate ☐Severe ☐Partial ☐Full Remission ☐Single or ☐Recurrent **Date & Results of PHQ9 Screening (must support diagnosis)** Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
☐Yes ☐No ☐Yes ☐No	Bipolar Disorder Schizophrenia	Type: ☐Mild ☐Moderate ☐Severe ☐Partial ☐Full Remission ☐Single or ☐Recurrent Exam Details:	☐Active/Stable ☐Resolved

Pre-Populated Member Information

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:	MD ☐ DO ☐ NP ☐ PA ☐			DOS:	______/______/__________

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☐Yes ☐No	Drug/Alcohol	Addiction: _________ Type:______ Frequency__________ Date Quit: ☐History Exam Details:	☐Active ☐Resolved
Endocrinology		☐ABNL Habitus ☐Goiter ☐ABNL GTT ☐Gynecomastia ☐Underweight ☐Generalized Weakness ☐Hypoglycemia ☐Polydypsia ☐Polyphagia ☐Polyuria ☐Tremors ☐Morbid Obesity ☐ Other_________	
☐Yes ☐No	Protein Calorie Mal-Nutrition	☐ Weight Loss ☐ Wasting ☐ Malnourished ☐ Supplements Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
☐Yes ☐No	★ Diabetes	Type: ☐1 ☐2 ☐Currently taking insulin **Complications:** ☐Gangrene in DM ☐Retinopathy in DM ☐ED in DM ☐Chronic Skin Ulcer in DM Fingerstick blood sugar range (low to high) for past month: Date and Result of last HgbA1c: Date and result of last Microalbuminura: Exam Details:	☐Active/Stable ☐Controlled ☐Uncontrolled
Hem/Onc			
☐Yes ☐No	Anemia	Type: ________________ In Neoplastic Disease: ☐Yes ☐No Date of Last CBC: _______ Hgb_________ HCT________ PLTS__________ Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
☐Yes ☐No	Neoplasm's	Site:__________________ ☐ Chemotherapy ☐ Radiation Type:_____________________ Exam Details:	☐Active/Stable ☐Progressive ☐Resolved
☐Yes ☐No	Metastatic	☐Yes ☐No Site:_________________ ☐ Chemotherapy ☐ Radiation Exam Details:	☐Active/Stable ☐Progressive ☐Resolved

Pre-Populated Member Information

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:		MD ☐ DO ☐ NP ☐ PA ☐		DOS:	_____/_____/_________

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Care for Older Adults (COA) Assessment – *For SNP Members Only*

Please see page 1 (box highlighted in RED with Yellow STAR next to it) If marked yes, please fill out this page.

ES ☐ NO

ised of their need to have an Advance Directive in place.) ☐

Medication Reconcilliation – CPT Codes: 90862, 99605, 99606 Category II Codes: 1159F, 1160F

NAME OF MEDICATION	PRESCRIPTION	O-T-C	DOSAGE
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Current Level of Function *(Compare to initial assessment.)* **Category II Codes: 1170F**

ADL	☐ INDEPENDENT ☐ MINIMAL ASSISTANCE ☐ NEEDS ASSISTANCE ☐ TOTAL ASSIST
MOBILITY	☐ CONTROLS/MOVES ALL LIMBS AT WILL AND SAFELY INDEPENDENT ☐CONTROLS/MOVES ALL LIMBS WITH MIN. ASSISTANCE ☐ REQUIRES 2 PERSONS FOR XFER ☐ UNABLE TO POSITION CHANGE/MECHANICAL LIFT XFER
BALANCE	☐ NORMAL ☐ MIN. ASSISTANCE WITH BALANCE ☐UNSAFE BALANCE AND NEEDS MODERATE ASSISTANCE ☐ MAXIMUM ASSISTANCE NEEDED WITH 1-2 PERSONS
MENTAL STATUS	☐ ORIENTED x3 ☐ ORIENTED x2 – FOLLOWS SIMPLE COMMANDS ☐ ORIENTED x1 – INCONSISTENLY RESTLESS, AGITATED OR NERVOUS ☐ UNRESPONSIVE TO VERBAL COMMANDS
COMMUNICATIONS	☐ IMPROVED ☐ DECLINED ☐ UNCHANGED

Pain Assessment – Category II Codes: 0521F, 1125F, 1125F

Location:	**Intensity:** On a scale of 0 to 10, with 0 being no at all and 10 being the worst pain you can imagine, how much does it hurt right now? 0-------1------2-------3-------4-------5-------6-------7-------8-------9-------10 *No Pain* *Moderate Pain* *Worst Pain Possible*
IS PAIN CONSTANT? ☐ YES ☐ NO	TYPE OF PAIN (Example: ache, deep, sharp, hot, cold, dull, like sensitive skin)
ONSET, DURATION, VARIATIONS	WHAT RELIEVES PAIN?
OTHER COMMENTS:	

Pre-Populated Member Information

Patient Name:	Member ID:	DOB:	
Provider Signature/ Credentials:	MD ☐ DO ☐ NP ☐ PA ☐	DOS:	______/______/__________

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The following information is required for each diagnosis on the Annual Visit Form

Add any additional diagnosis not mentioned in the "Assessment Plan" on the next page here.

	Diagnosis Description	Status of Diagnosis	Plan Of Care
Diagnosis #1		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-9 #1			Current RX:
Diagnosis #2		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-9 #2			Current RX:
Diagnosis #3		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-9 #3			Current RX:
Diagnosis #4		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-9 #4			Current RX:
Diagnosis #5		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-9 #5			Current RX:
Diagnosis #6		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-9 #6			Current RX:
Diagnosis #7		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-9 #7			Current RX:
Diagnosis #8		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-9 #8			Current RX:
Diagnosis #9		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-9 #9			Current RX:
Diagnosis #10		☐Active/Stable ☐Acute ☐Declining ☐ END Stage ☐Resolved	Plan of Care:
ICD-9 #10			Current RX:
Health Maintenance:			
Referrals:			
New RX in the last 180 days			

Pre-Populated Member Information

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:		MD ☐ DO ☐ NP ☐ PA ☐		DOS:	______/______/__________

Date / Time Printed

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Assessment Plan

Home Address

Carrier Eligibility

Please ensure there is an **assessment check box marked** and **plan** for every diagnosis. This is a **requirement** for the AV to be considered complete for incentive payment.

Fax:

Check only one (1) box per diagnosis. More than 1 box checked will be considered not complete and will delay payment.

DX Code	Description	Assessment				
296.21	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MILD DEGREE	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
296.22	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MODERATE DEGREE	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	STAGE V OR END STAGE RENAL DISEASE					by PCP
	Plan:					
412	OLD MYOCARDIAL INFARCTION	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
413.9	OTHER AND UNSPECIFIED ANGINA PECTORIS	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
427.31	ATRIAL FIBRILLATION	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
496	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
585.4	CHRONIC KIDNEY DISEASE, STAGE IV (SEVERE)	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					

Each diagnosis not Resolved, MUST have a plan of care written out and must be legible for treatment of the above diagnosis. No plan of care written out will be considered not complete and will delay payment.

If you cannot validate this diagnosis please mark the box labeled "DX not followed by PCP"

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:		MD ☐ DO ☐ NP ☐ PA ☐		DOS:	______/______/_________

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Suspected Conditions

Please confirm or deny if condition is applicable and notate under the New Diagnosis and Treatment Plan below

Suspected conditions are based on historical data

Each valid, active diagnosis **MUST** have a Plan of Care written out and be legible.

DX Code	Description	Assessment				
	Member with Rheumatoid Arthritis & Inflammatory Connective Disease Recaptured	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	Member with Heart Arrhythmias and not Recaptured	Stable	Resolved	Worsening	Improving	DX not followed
						ed
	Plan:					
	496 - Member with COPD and not Reaptured	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	Member with Inflammatory Bowel Disease and not Recaptured	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	250.7x - Diabetic Member coded with CAD or Atherosclerosis and not coded with Peripheral Vascular Complications	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	Member with history of MI or angina and not coded with Vascular Disease	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	Member with Coronary Atherosclerosis and not coded with Angina	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	250.4x - Diabetic Member not coded with Renal Complications	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	250.4x - Diabetic Member presents renal complications	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	250.8x - Diabetic Member not coded with other Specified Manifestations	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	Member with COPD and prescribed home oxygen and not coded for Chronic Respiratory Failure	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					
	Member coded with depression NOS, anxiety disorder, generalized anxiety disorder or panic attacks and not coded with Major Depressive Disorder	Stable	Resolved	Worsening	Improving	DX not followed by PCP
	Plan:					

Patient Name:		Member ID:		DOB:	
Provider Signature/ Credentials:		MD ☐ DO ☐ NP ☐ PA ☐		DOS:	______/______/__________