

AV Incentive Payment is only payable upon accurate completion of Annual Visit form. Every field must be completed for incentive payment.

Height: _____ Weight: _____ **★ BMI:** _____ HR: _____ **★ BP Result** _____ / _____ / _____ mm hg

Date of last Flu Vaccine ★ _____ / _____ / _____ Date of Last DEXA (Bone Density Test) Results: _____

Past Medical & Family History: **HEDIS STAR MEASURES**

Chief Compliant

★ SNP Member: YES NO

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 Monitored, Evaluated and Assessed. Treatment plan must be provided on the last page. If the form is not complete it will be returned.

<input type="checkbox"/> Yes <input type="checkbox"/> No	Cataracts	<input type="checkbox"/> RT <input type="checkbox"/> LT or <input type="checkbox"/> Both Eyes <input type="checkbox"/> Due to Diabetes Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No (<input type="checkbox"/> RT <input type="checkbox"/> LT or <input type="checkbox"/> Both eyes)	<input type="checkbox"/> Active/Stable <input type="checkbox"/> Progressive
<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinopathy	Due to Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No Due to HTN? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last Dilated or Retinal Eye Exam _____ / _____ / _____ <input type="checkbox"/> Normal <input type="checkbox"/> Positive for Retinopathy Eye Provider Name: _____	<input type="checkbox"/> Active/Stable <input type="checkbox"/> Uncontrolled
<input type="checkbox"/> Yes <input type="checkbox"/> No	★ Glaucoma Document name of physician who performed glaucoma screen: _____	<input type="checkbox"/> Due to Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Ophthalmologist <input type="checkbox"/>	<input type="checkbox"/> Active/Stable <input type="checkbox"/> Progressive
Cardiovascular			
<input type="checkbox"/> Chest Pain <input type="checkbox"/> Dyspnea <input type="checkbox"/> Palpitation <input type="checkbox"/> Syncope <input type="checkbox"/> Previous MI <input type="checkbox"/> Diaphoresis <input type="checkbox"/> Reynaud's <input type="checkbox"/> Claudication <input type="checkbox"/> Cool Extremities <input type="checkbox"/> Cyanosis <input type="checkbox"/> Edema <input type="checkbox"/> Erythema <input type="checkbox"/> Pain in Extremities			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Failure	<input type="checkbox"/> CHF right or left ventricle failure <input type="checkbox"/> Left HF <input type="checkbox"/> Systolic HF <input type="checkbox"/> Diastolic HF <input type="checkbox"/> Unspecified HF <input type="checkbox"/> Combined Sysolic/Diastolic HF Last BNP Result: _____ Last Echo: _____ Ejection Fraction %: _____ Exam Details	<input type="checkbox"/> Active/Stable <input type="checkbox"/> Progressive <input type="checkbox"/> Resolved
<input type="checkbox"/> Yes <input type="checkbox"/> No	CAD/ASHD Old MI	<input type="checkbox"/> Affecting Native Vessel <input type="checkbox"/> Affecting BP-Graft (type of graft) Exam Details: _____ Date of Event: _____	<input type="checkbox"/> Active/Stable <input type="checkbox"/> Resolved
<input type="checkbox"/> Yes <input type="checkbox"/> No	Arrhythmia	Type: _____ Date and Result of Last EKG: _____ Pacemaker Y/N Reason: _____	<input type="checkbox"/> Active/Stable <input type="checkbox"/> Uncontrolled <input type="checkbox"/> Resolved
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sick Sinus Heart Block Angina	<input type="checkbox"/> Tachycardia-Bradycardia Type: _____ Type: _____ Exam Details: _____	<input type="checkbox"/> Active/Stable <input type="checkbox"/> Acute <input type="checkbox"/> Uncontrolled <input type="checkbox"/> Resolved

Pre-Populated Member Information

Patient Name: _____ Member ID: _____ DOB: _____

Provider Signature/ Credentials: _____ MD DO NP PA DOS: _____ / _____ / _____

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

HEDIS STAR MEASURES

Pre-Populated Member Information

Musculoskeletal		<input type="checkbox"/> Ambulation/Gait Changes <input type="checkbox"/> Back Pain <input type="checkbox"/> Myalgias <input type="checkbox"/> Join/bone Symptom <input type="checkbox"/> Rheumatologic Manifestations	
Patient Name:	Member ID:	DOB:	
Provider Signature/ Credentials:	MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/>	DOS:	___/___/___

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

Pre-Populated Member Information

Patient Name:	Member ID:	DOB:
Provider Signature/ Credentials:	MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/>	DOS: ___/___/___

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<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug/Alcohol	Addiction: _____ Type: _____ Frequency _____ Date Quit: _____ <input type="checkbox"/> History Exam Details: _____	<input type="checkbox"/> Active <input type="checkbox"/> Resolved
Endocrinology		<input type="checkbox"/> ABNL Habitus <input type="checkbox"/> Goiter <input type="checkbox"/> ABNL GTT <input type="checkbox"/> Gynecomastia <input type="checkbox"/> Underweight <input type="checkbox"/> Generalized Weakness <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Polydypsia <input type="checkbox"/> Polyphagia <input type="checkbox"/> Polyuria <input type="checkbox"/> Tremors <input type="checkbox"/> Morbid Obesity <input type="checkbox"/> Other _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Protein Calorie Mal-Nutrition	<input type="checkbox"/> Weight Loss <input type="checkbox"/> Wasting <input type="checkbox"/> Malnourished <input type="checkbox"/> Supplements Exam Details: _____	<input type="checkbox"/> Active/Stable <input type="checkbox"/> Progressive <input type="checkbox"/> Resolved
<input type="checkbox"/> Yes <input type="checkbox"/> No	★ Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Currently taking insulin Complications: <input type="checkbox"/> Gangrene in DM <input type="checkbox"/> Retinopathy in DM <input type="checkbox"/> ED in DM <input type="checkbox"/> Chronic Skin Ulcer in DM Fingertick blood sugar range (low to high) for past month: _____ Date and Result of last HgbA1c: _____ Date and result of last Microalbuminura: _____ Exam Details: _____	<input type="checkbox"/> Active/Stable <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled
Hem/Onc			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	Type: _____ In Neoplastic Disease: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Last CBC: _____ Hgb _____ HCT _____ PLTS _____ Exam Details: _____	<input type="checkbox"/> Active/Stable <input type="checkbox"/> Progressive <input type="checkbox"/> Resolved
<input type="checkbox"/> Yes <input type="checkbox"/> No	Neoplasm's	Site: _____ <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation Type: _____ Exam Details: _____	<input type="checkbox"/> Active/Stable <input type="checkbox"/> Progressive <input type="checkbox"/> Resolved
<input type="checkbox"/> Yes <input type="checkbox"/> No	Metastatic	<input type="checkbox"/> Yes <input type="checkbox"/> No Site: _____ <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation Exam Details: _____	<input type="checkbox"/> Active/Stable <input type="checkbox"/> Progressive <input type="checkbox"/> Resolved

Pre-Populated Member Information

Patient Name:	Member ID:	DOB:
Provider Signature/ Credentials:	MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/>	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.

YES NO
 (based on their need to have an Advance Directive in place.)

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

NAME OF MEDICATION	PRESCRIPTION	O-T-C	DOSAGE
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

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

ADL	<input type="checkbox"/> INDEPENDENT <input type="checkbox"/> MINIMAL ASSISTANCE <input type="checkbox"/> NEEDS ASSISTANCE <input type="checkbox"/> TOTAL ASSIST
MOBILITY	<input type="checkbox"/> CONTROLS/MOVES ALL LIMBS AT WILL AND SAFELY INDEPENDENT <input type="checkbox"/> CONTROLS/MOVES ALL LIMBS WITH MIN. ASSISTANCE <input type="checkbox"/> REQUIRES 2 PERSONS FOR XFER <input type="checkbox"/> UNABLE TO POSITION CHANGE/MECHANICAL LIFT XFER
BALANCE	<input type="checkbox"/> NORMAL <input type="checkbox"/> MIN. ASSISTANCE WITH BALANCE <input type="checkbox"/> UNSAFE BALANCE AND NEEDS MODERATE ASSISTANCE <input type="checkbox"/> MAXIMUM ASSISTANCE NEEDED WITH 1-2 PERSONS
MENTAL STATUS	<input type="checkbox"/> ORIENTED x3 <input type="checkbox"/> ORIENTED x2 – FOLLOWS SIMPLE COMMANDS <input type="checkbox"/> ORIENTED x1 – INCONSISTENTLY RESTLESS, AGITATED OR NERVOUS <input type="checkbox"/> UNRESPONSIVE TO VERBAL COMMANDS
COMMUNICATIONS	<input type="checkbox"/> IMPROVED <input type="checkbox"/> DECLINED <input type="checkbox"/> 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 <i>No Pain</i> <i>Moderate Pain</i> <i>Worst Pain Possible</i>
IS PAIN CONSTANT? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/>	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		<input type="checkbox"/> Active/Stable <input type="checkbox"/> Acute <input type="checkbox"/> Declining <input type="checkbox"/> END Stage <input type="checkbox"/> Resolved	Plan of Care:
ICD-9 #1			Current RX:
Diagnosis #2		<input type="checkbox"/> Active/Stable <input type="checkbox"/> Acute <input type="checkbox"/> Declining <input type="checkbox"/> END Stage <input type="checkbox"/> Resolved	Plan of Care:
ICD-9 #2			Current RX:
Diagnosis #3		<input type="checkbox"/> Active/Stable <input type="checkbox"/> Acute <input type="checkbox"/> Declining <input type="checkbox"/> END Stage <input type="checkbox"/> Resolved	Plan of Care:
ICD-9 #3			Current RX:
Diagnosis #4		<input type="checkbox"/> Active/Stable <input type="checkbox"/> Acute <input type="checkbox"/> Declining <input type="checkbox"/> END Stage <input type="checkbox"/> Resolved	Plan of Care:
ICD-9 #4			Current RX:
Diagnosis #5		<input type="checkbox"/> Active/Stable <input type="checkbox"/> Acute <input type="checkbox"/> Declining <input type="checkbox"/> END Stage <input type="checkbox"/> Resolved	Plan of Care:
ICD-9 #5			Current RX:
Diagnosis #6		<input type="checkbox"/> Active/Stable <input type="checkbox"/> Acute <input type="checkbox"/> Declining <input type="checkbox"/> END Stage <input type="checkbox"/> Resolved	Plan of Care:
ICD-9 #6			Current RX:
Diagnosis #7		<input type="checkbox"/> Active/Stable <input type="checkbox"/> Acute <input type="checkbox"/> Declining <input type="checkbox"/> END Stage <input type="checkbox"/> Resolved	Plan of Care:
ICD-9 #7			Current RX:
Diagnosis #8		<input type="checkbox"/> Active/Stable <input type="checkbox"/> Acute <input type="checkbox"/> Declining <input type="checkbox"/> END Stage <input type="checkbox"/> Resolved	Plan of Care:
ICD-9 #8			Current RX:
Diagnosis #9		<input type="checkbox"/> Active/Stable <input type="checkbox"/> Acute <input type="checkbox"/> Declining <input type="checkbox"/> END Stage <input type="checkbox"/> Resolved	Plan of Care:
ICD-9 #9			Current RX:
Diagnosis #10		<input type="checkbox"/> Active/Stable <input type="checkbox"/> Acute <input type="checkbox"/> Declining <input type="checkbox"/> END Stage <input type="checkbox"/> 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 <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/>	DOS: ____/____/____

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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				DX not followed by PCP
		Stable	Resolved	Worsening	Improving	
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 IV CHRONIC KIDNEY 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

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

Suspected conditions are based on historical data

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

Patient Name:	Member ID:	DOB:
Provider Signature/ Credentials:	MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/>	DOS: ____/____/____