Annual Wellness Visit Provider Form

MEMBER NAME: __________________________ DOB: ______________

PROVIDER SIGNATURE __________________________ Date of service: ___/___/___

Services provided

___ Initial Preventive Physical Exam (IPPE) G0402 (During first 12 months of Medicare enrollment)

___ Initial Annual Wellness Visit with a personalized prevention plan of service (AWV with PPPS) G0438
(after 12 months and has not received an IPPE or AWV within the past 12 months)

___ Subsequent AWV with a personalized prevention plan of service (Subsequent AWV with a PPPS) G0439
(has not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months)

Optional Element of AWV

___ Advanced Care Planning CPT-99497 (To include the explanation and discussion of advanced directives
such as standard forms (with completion of such forms, when performed), by the physician or other
qualified health care professional: first 30 minutes, face to face with patient, family member(s) and /or
surrogate. (A diagnosis code is required and should be consistent with a beneficiaries exam)

___ Advanced care planning CPT-99498 - same requirements as above for each additional 30 minutes (List
separately in addition to code for primary procedure)

Please Complete form (4 pages) and attach office visit note:

Fax to 1-860-907-3724

OR

Upload to the provider portal to HEDIS Record Submission category

SAVE COPY IN MEMBERS CHART

Acquire / Update Member Information

(Acquire / Update patient’s medical and social history)

1. **Administer HRA** (Initial AWV and Subsequent AWV with PPPS)

   Collect self-reported information from member: at a minimum address the following topics:

   ___ Demographic data
   ___ Self-assessment of health status
   ___ Psychosocial risks
   ___ Behavioral risks
   ___ Activities of Daily Living including, but not limited to dressing, bathing and walking
   ___ Instrumental ADL’s, including but not limited to: shopping, housekeeping, managing own
   medications and handling finances
2. **Establish/ Update a list of current providers and suppliers:**
   ___ Current providers
   ___ Suppliers
   ___ Pharmacy
   ___ Any providers involved in providing medical care

3. **Establish /Update Members Medical/Social History and Family History**
   ___ Past Medical History: illnesses, hospital stays, injuries, treatments
   ___ Past Surgical History: operations
   ___ Current Medications/Supplements/Vitamins/Allergies
   ___ Family history: Medical events of parents, siblings and children: diseases that may be hereditary or place member at risk
   ___ History of Alcohol/ Tobacco/ Illicit Drugs
   ___ Physical Activity
   ___ Pain Assessment

4. **Review members potential risk factors for depression including current or past experiences with depression or other mood disorder**
   ___ Depression screening *(Initial AWV only)*

5. **Review /Update members functional ability and level of safety**
   ___ Hearing Impairment
   ___ Ability to successfully preform ADL/IADL *(initial and subsequent)*
   ___ Fall risk
   ___ Home safety

---

**Begin Assessment and Discussion**
*(Physical Exam and Discussion)*

---

1. **Exam**
   ___ Height
   ___ Weight
   ___ Body Mass Index
   ___ Blood Pressure
   ___ Visual acuity
   ___ Other factors deemed appropriate based upon the members medical and social history and current clinical standards

2. **Establish / Update / Detect any cognitive impairment member may have**
   ___ Direct observation
   ___ Obtained by family, friends, caretakers or others
1. Establish/Update a written screening schedule for member, checklist for next 5-10 years as Appropriate

Scheduled date for appropriate screenings and other preventative services:

DATE: ______________ Abdominal Aortic Aneurysm Screening ultrasound
DATE: ______________ Alcohol Misuse Screening and Counseling
DATE: ______________ Bone Mass Measurement (Bone Density Test)
DATE: ______________ Cardiovascular Disease (Behavioral Therapy) CVD risk reduction visit
DATE: ______________ Cervical Cancer screening with Human Papillomavirus test (HPV)
DATE: ______________ Cardiovascular Screenings (cholesterol, lipids, triglycerides)
DATE: ______________ Colorectal Cancer Screening: (Please fill in completion date below)
DATE: ______________ FOBT/FIT
DATE: ______________ FIT DNA
DATE: ______________ Colonoscopy
DATE: ______________ Sigmoidoscopy
DATE: ______________ Colonography
DATE: ______________ Depression Screening
DATE: ______________ Diabetes Screening: A1C, nephropathy, eye exam
DATE: ______________ Diabetes Self-Management Training
DATE: ______________ Influenza Virus Vaccine and administration
DATE: ______________ Glaucoma Test
DATE: ______________ Hepatitis B Virus Vaccine and administration
DATE: ______________ Hepatitis C Screening
DATE: ______________ HIV Screening
DATE: ______________ Lung Cancer Screening counseling and Low dose computed Tomography (LDCT)
DATE: ______________ Mammogram screening
DATE: ______________ Medical Nutrition Therapy Services
DATE: ______________ Obesity Screening and Counseling
DATE: ______________ Pap test and Pelvic exam (included breast exam)
DATE: ______________ Pneumococcal Vaccine and administration
DATE: ______________ Prostate Cancer screening
DATE: ______________ Sexually Transmitted Infections Screenings and High intensity counseling to prevent STIs
DATE: ______________ Tobacco use cessation (counseling to stop smoking)
DATE: ______________ * Once in lifetime screening EKG/ECG as appropriate*

2. Establish /Update a list of risk factors and conditions for which the primary, secondary, or tertiary interventions are recommended or underway for member

_____ Any mental health conditions or risk factors or conditions identified through and IPPE
_____ A list of treatment options and their associated risks and benefits

MEMBER NAME: _______________________________________________________________ DOB: ______________
H5580_P_18_027 QB 2271
3. _______ Educate, Counsel and refer based on previous components and other preventative services when appropriate

4. _______ Furnish personalized health advice to member and a referral as appropriate to health education or preventive counseling services or programs
   DATE: _______ Community based lifestyle interventions to reduce health risks and promote Self-management and wellness
   DATE: _______ Fall prevention
   DATE: _______ Nutrition
   DATE: _______ Physical activity
   DATE: _______ Tobacco-use cessation
   DATE: _______ Weight loss

5. **End of life planning, Advanced Directives**
   Examples: Living will, health care power of attorney, health care proxy, physician Orders for Life sustaining treatment, five wishes, written document designating a surrogate decision maker, documentation of a conversation with relatives/friend about life sustaining treatment and end of life care
   ___ Discussion of Advanced Directives
   ___ Verbal or written information provided to member if no plan is noted
   ___ Are you willing to follow member’s wishes as expressed in advanced directive?

Generally, you may provide other medically necessary services on the same date of service as an AWV. The deductible and coinsurance/copayment apply for these other medically necessary services.

When you provide a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service in addition to the AWV, Medicare may pay for the additional service. Report the Current Procedural Terminology (CPT) code with modifier -25. That portion of the visit must be medically necessary to treat the beneficiary’s illness or injury or to improve the functioning of a malformed body member.

The AWV does not include any clinical laboratory tests, but you may make referrals for such tests as part of the AWV, if appropriate.

You must report a diagnosis code when submitting a claim for Advanced Care Planning as an optional element of AWV. Since you are not required to document a specific diagnosis code for ACP as an optional element AWV, you may choose any diagnosis code consistent with a beneficiary’s exam.

**Please Complete form (4 pages) and attach office visit note:**

Fax to 1-860-907-3724

OR

Upload to the provider portal to HEDIS Record Submission category

SAVE COPY IN MEMBERS CHART