CareFirst Medicare Advantage

2021 Annual Wellness Exam

Provider: This form is two sided. Please complete all fields and fax this form and proof of service to CareFirst BlueCross BlueShield Medicare Advantage at 410-779-3957 so your patient can redeem their reward card.

Name: _____

Member ID: _____ Date of Birth: _____

Name of Provider: _____ Date of Visit: _____

Practice Name: _____ NPI: _____

Address: _____

Phone: _____ Fax: _____

Measures:

Blood Pressure: _____/_____ Weight: _____lbs. Height: _____ BMI: _____

Activities of Daily Living: Does the patient require assistance with any of the following?

Bathing	☐ YES	☐ NO	☐ N/A
Dressing	☐ YES	☐ NO	☐ N/A
Eating	☐ YES	☐ NO	☐ N/A
Walking	☐ YES	☐ NO	☐ N/A
Using the toilet	☐ YES	☐ NO	☐ N/A
Transferring (ex. getting in & out of chairs)	☐ YES	☐ NO	☐ N/A
Can the patient perform all activities of daily living independently?	☐ YES	☐ NO	☐ N/A
Physical Activity: Did you discuss the patient's level of physical activity and provide advice to start, increase, or maintain levels as appropriate?	☐ YES	☐ NO	☐ N/A
Balance/Falls: Does the patient have any trouble walking or standing?	☐ YES	☐ NO	☐ N/A
Fallen in the last 12 months?	☐ YES	☐ NO	☐ N/A
If yes, discuss treatment options. _____			
Urine Leakage: Any urine leakage?	☐ YES	☐ NO	☐ N/A
Does it interfere with sleep or daily activities?	☐ YES	☐ NO	☐ N/A
If yes, discuss treatment options. _____			
Smoking: Does the patient smoke?	☐ YES	☐ NO	☐ N/A
Did you advise smoker to quit?	☐ YES	☐ NO	☐ N/A
Did you discuss smoking cessation medication and/or strategies?	☐ YES	☐ NO	☐ N/A
Medication Review: Is the patient taking medication?	☐ YES	☐ NO	☐ N/A

Please list all medications, including OTC and herbal or supplemental therapies prescribed or attach a signed and dated copy of the medication list.

TYPE	MEDICATION	DOSE/FREQ.
Cholesterol		
Diabetes		
Blood Pressure		

Did you assess for non-adherence (missing more than one dose/week and address any barriers)? ☐ YES ☐ NO ☐ N/A

Has the patient been diagnosed with rheumatoid arthritis? ☐ YES ☐ NO ☐ N/A

If yes, is the patient on a DMARD? ☐ YES ☐ NO ☐ N/A

If no, why not? _____

Comprehensive Pain Assessment: Does the patient have pain? 0: Does not hurt 10: Hurts the most

Indicate level of pain for the head/neck 0 1 2 3 4 5 6 7 8 9 10 Freq. _____

Indicate level of pain for the chest 0 1 2 3 4 5 6 7 8 9 10 Freq. _____

Indicate level of pain for the muscles 0 1 2 3 4 5 6 7 8 9 10 Freq. _____

Indicate level of pain for bones/joints 0 1 2 3 4 5 6 7 8 9 10 Freq. _____

Indicate level of pain for other _____ 0 1 2 3 4 5 6 7 8 9 10 Freq. _____

Is the pain under a pain management plan? ☐ YES ☐ NO ☐ N/A

Annual Preventive Measures: Has the patient completed the following important screenings?

Mammogram (for women 50-74 years of age) ☐ YES ☐ NO ☐ N/A

Colorectal Cancer Screening (for patients 50-75 years of age) ☐ YES ☐ NO ☐ N/A

Dilated Retinal Eye Exam (for diabetic patients up to 75 years of age) ☐ YES ☐ NO ☐ N/A

Annual Flu Vaccine (for all patients) Date completed: _____ ☐ YES ☐ NO ☐ N/A

Advanced Care Planning: Does the patient have evidence of advanced care planning directives in the medical record? ☐ YES ☐ NO ☐ N/A

Name of Office Staff Member Completing Form: _____

Provider's Signature: _____

Provider Use Only: Please use the following coding guidance to document the annual wellness visit:

Annual Wellness Visit: G0438 or G0439 (HCPCS Code)

BMI: Z68.20-Z68.24 or Z68.51-Z68.54

Functional Status: 1170F or 99483

Pain Assessment: 1125F, or 1126F