



# Medicare Advantage Annual Wellness Visit

Patient Last Name, First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_

- Once-in-a-lifetime Initial Preventive Physical Examination (G0402)
- Once-in-a-lifetime Initial Annual Wellness Visit (G0438)
- Subsequent AWW (G0439)

Please note: Federally Qualified Health Center visit, IPPE or AWW use code G0468.

This form and its accompanying **Medicare Advantage Annual Wellness Visit Guide** may be helpful to follow during our Medicare Advantage members' wellness visits. The guide is in the [Clinical Resources section of our website](#) under Preventive Care Guidelines.

## General Patient Info

Age \_\_\_\_\_ Gender \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Health Status \_\_\_\_\_ Frailty \_\_\_\_\_

Physical Function \_\_\_\_\_ Hearing Impairment  None \_\_\_\_\_

## Risk Factors

Depression  None \_\_\_\_\_ Life Satisfaction  Good \_\_\_\_\_

Stress  None \_\_\_\_\_ Anger  None \_\_\_\_\_

Loneliness/Social Isolation  None \_\_\_\_\_ Pain/Fatigue  None \_\_\_\_\_

Tobacco Use  Never  Quit  Packs per day \_\_\_\_\_  Pack year history \_\_\_\_\_ Illicit Drug Use  Never  Quit \_\_\_\_\_

Alcohol Use  Never  Quit  Alcohol equivalents per day \_\_\_\_\_

Physical Activity  Exercise \_\_\_\_\_ days per week for \_\_\_\_\_ minutes per episode \_\_\_\_\_

Diet/Nutrition  Good without lack \_\_\_\_\_ Oral Health  Brush/floss regularly \_\_\_\_\_

Seat Belt Use in Vehicle  Always use \_\_\_\_\_ Sexual Health \_\_\_\_\_

Home Safety  Safe \_\_\_\_\_

Family History (Medical Events/Hereditary Disease) \_\_\_\_\_

## Activities of Daily Living

Dressing  No Difficulty \_\_\_\_\_ Feeding  ND \_\_\_\_\_ Toileting  ND \_\_\_\_\_

Grooming  ND \_\_\_\_\_ Balance/Risk of Falls  ND \_\_\_\_\_

Bathing  ND \_\_\_\_\_ Walking  ND \_\_\_\_\_

## Instrumental ADLs

Shopping  ND \_\_\_\_\_ Food Preparation  ND \_\_\_\_\_ Using Phone  ND \_\_\_\_\_

Housekeeping  ND \_\_\_\_\_ Laundry  ND \_\_\_\_\_ Transportation  ND \_\_\_\_\_

Manage Own Medications  ND \_\_\_\_\_

Handle Finances  ND \_\_\_\_\_

## Visit History

Last Wellness Visit: Date \_\_\_\_\_ Provider/Location \_\_\_\_\_

If Diabetic, Last Diabetic Eye Exam: Date \_\_\_\_\_ Provider/Location \_\_\_\_\_

Last Hospitalization: Date \_\_\_\_\_ Provider/Location \_\_\_\_\_



Patient Last Name, First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_

Medical History

- Medical history checklist including Anemia, Asthma, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, etc.

Surgical History

- Surgical history checklist including Amputation, Appendectomy, Breast surgery, Carotid endarterectomy, etc.

Allergies

Allergies section with checkboxes for drug allergies and a field for supplements including calcium and vitamins.

Medications (Type, dose, route, frequency)



Patient Last Name, First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_

**Physical Exam**

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_

Blood pressure (If blood pressure is above 139/89, please retake and record the second blood pressure reading) \_\_\_\_\_

Pain assessment on scale of 0 to 10 (10 is worst) \_\_\_\_\_

Visual acuity screen (for IPPE):

**Detection of Any Cognitive Impairment**

Direct observation; patient reports; concerns raised by family members, friends or caretakers; other:

**Risk Factors for Depression and Anxiety**

Current and/or past experiences with depression or anxiety

Patient Health Questionnaire (PHQ-9)  Score four or less

Generalized Anxiety Disorder (GAD-7)  Score four or less

No current and/or past experiences with depression or anxiety

Current and/or past experiences with other mood disorders (e.g. bipolar disorder, adverse reactions to antidepressants)

*Specify:* \_\_\_\_\_

**Current Providers, Specialists and Pharmacies** (In-home delivery company and local pharmacy)



Patient Last Name, First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_

Establish a written screening schedule, such as a checklist, for the next five to 10 years based on recommendations from the following resources and the member's health risk assessment, health status and screening history:

- [U.S. Preventive Services Task Force](#) (see below for nonpregnant members)
- [Advisory Committee on Immunization Practices](#)
- Age-appropriate [preventive services covered by Medicare](#) (see Annual Wellness Visit Guide)

Establish a list of risk factors and conditions that have a recommended intervention (see below table)

**U.S. Preventative Services Task Force A and B Recommendations**

ELIGIBLE	TEST	GENDER	AGES	OTHER CRITERIA	RECOMMENDATION	SCHEDULE
<input type="checkbox"/>	Abdominal aortic aneurysm screening	Men	65 to 75	Ever smoked	One-time screening with ultrasonography	
<input type="checkbox"/>	Anxiety disorder in adults	All	19 to 64	Don't currently have a diagnosed mental health disorder	Screen for anxiety	
<input type="checkbox"/>	Blood pressure screening	All	18 and older	Obtain measurements outside the clinical setting for diagnostic confirmation before starting treatment	Screen for hypertension	
<input type="checkbox"/>	Breast cancer gene risk assessment and genetic counseling/testing	Women		Personal or family history of breast, ovarian, tubal or peritoneal cancer or ancestry associated with BRCA1 or BRCA2 gene mutations, use familial risk assessment tool	If positive result on risk assessment tool then give genetic counseling and, if indicated after counseling, genetic testing	
<input type="checkbox"/>	Breast cancer preventive medications	Women		Increased risk for breast cancer and at low risk for adverse medication side effects	Offer risk-reducing medications such as tamoxifen, raloxifene or aromatase inhibitors	
<input type="checkbox"/>	Breast cancer screening	Women	40 to 74	Biennial screening mammography with or without clinical breast examination		
<input type="checkbox"/>	Cervical cancer screening	Women	21 to 29	Screen with cervical cytology alone every 3 years		
			30 to 65	As above or hrHPV testing alone every 5 years or hrHPV + cytology every 5 years		
<input type="checkbox"/>	Chlamydia screening	Women	24 or younger	Sexually active	Screen for chlamydia	
			25 and older	Increased risk for infection		
<input type="checkbox"/>	Colorectal cancer screening	All	45 to 75		Screen for cancer	
<input type="checkbox"/>	Depression screening	All	18 and older	Screen with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up		
<input type="checkbox"/>	Diabetes screening	All	35 to 70	Overweight or obese	Screen for abnormal blood glucose and offer or refer if abnormal to intensive behavioral counseling interventions to promote a healthy diet and physical activity	
<input type="checkbox"/>	Fall prevention	All	65 and older	Community-dwelling at increased risk for falls	Exercise interventions to prevent falls	
<input type="checkbox"/>	Folic acid supplementation	All	See other criteria	Planning or capable of pregnancy	Take folic acid supplement: 0.4 to 0.8 mg per day	
<input type="checkbox"/>	Gonorrhea screening	Women	24 or younger	Sexually active	Screen for gonorrhea	
			25 and older	Increased risk for infection		
<input type="checkbox"/>	Healthy diet and physical activity counseling to prevent cardiovascular disease	All	18 and older	Overweight or obese with additional cardiovascular disease risk factors	Intensive behavioral counseling interventions to promote healthy diet and physical activity for CVD prevention	
<input type="checkbox"/>	Hepatitis B screening: adolescents and adults (nonpregnant)	All		High risk for infection	Screen for hepatitis B virus infection	



Patient Last Name, First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_

**U.S. Preventative Services Task Force A and B Recommendations**

ELIGIBLE	TEST	GENDER	AGES	OTHER CRITERIA	RECOMMENDATION	SCHEDULE
<input type="checkbox"/>	Hepatitis C virus infection screening	All	18 to 79	High risk for infection or if born between 1945 and 1965 (inclusive) offer one-time screening	Screen for HCV infection	
<input type="checkbox"/>	HIV pre-exposure prophylaxis for the prevention of HIV infection			High risk of HIV acquisition	Offer PrEP with effective antiretroviral therapy	
<input type="checkbox"/>	HIV screening: adolescents and adults (nonpregnant)	All	15 to 65		Screen for HIV infection	
			< 15 or > 65	At increased risk		
<input type="checkbox"/>	Intimate partner violence screening	Women	Reproductive age	Screen for intimate partner violence. If positive, then provide or refer to ongoing support services.		
<input type="checkbox"/>	Lung cancer screening	All	50 to 80 without a substantial limit to life expectancy	20 pack-year history and current smoker or within 15 years since quitting and without a health problem that would limit ability or willingness to have curative lung surgery	Low-dose computed tomography	
<input type="checkbox"/>	Obesity screening and counseling	All	Any	BMI >= 30	Intensive multicomponent behavioral interventions	
<input type="checkbox"/>	Osteoporosis screening	Women	64 and younger	Postmenopausal and at increased risk of osteoporosis as determined by a formal risk assessment tool (e.g. FRAX)	Screen for osteoporosis with bone measurement testing	
			65 and older		Screen as above	
<input type="checkbox"/>	Sexually transmitted infections counseling	All	Reproductive age	Increased risk for sexually transmitted infections	Intensive behavioral counseling	
<input type="checkbox"/>	Skin cancer behavioral counseling	All	24 and younger	Fair skin type	Counseling to minimize exposure to UV radiation	
<input type="checkbox"/>	Statin preventive medication	All	40 to 75	All the following: no history of CVD, >= 1 CVD risk factors (i.e. dyslipidemia, diabetes, hypertension or smoking) and 10-year cardiovascular risk of >= 10%	Low- to moderate-dose statin	
<input type="checkbox"/>	Syphilis screening: nonpregnant	All	Any	At increased risk for infection	Screen for syphilis	
<input type="checkbox"/>	Tobacco use counseling and interventions: nonpregnant adults	All	Any		Advise to stop using, provide behavioral interventions and FDA-approved medication for cessation	
<input type="checkbox"/>	Tuberculosis screening	All	18 and older	Populations at increased risk	Screen for latent TB	
<input type="checkbox"/>	Unhealthy alcohol use	All	18 and older	Risky or hazardous drinking	Brief behavioral counseling interventions to reduce unhealthy alcohol use	
<input type="checkbox"/>	Unhealthy drug use	All	18 and older	Don't currently have a diagnosed drug use disorder	Ask questions about unhealthy drug use	

<b>RISK FACTOR/CONDITION</b>
<b>TREATMENT OPTIONS</b>
<b>ASSOCIATED RISKS/BENEFITS</b>



Patient Last Name, First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_

**Condition Confirmation**

ICD-10	CONDITION	STATUS	PLAN	IMPRESSION
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic <input type="checkbox"/> Unknown	<input type="checkbox"/> Continue <input type="checkbox"/> Change <input type="checkbox"/> Monitor <input type="checkbox"/> Work up	
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic <input type="checkbox"/> Unknown	<input type="checkbox"/> Continue <input type="checkbox"/> Change <input type="checkbox"/> Monitor <input type="checkbox"/> Work up	
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic <input type="checkbox"/> Unknown	<input type="checkbox"/> Continue <input type="checkbox"/> Change <input type="checkbox"/> Monitor <input type="checkbox"/> Work up	
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic <input type="checkbox"/> Unknown	<input type="checkbox"/> Continue <input type="checkbox"/> Change <input type="checkbox"/> Monitor <input type="checkbox"/> Work up	
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic <input type="checkbox"/> Unknown	<input type="checkbox"/> Continue <input type="checkbox"/> Change <input type="checkbox"/> Monitor <input type="checkbox"/> Work up	
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic <input type="checkbox"/> Unknown	<input type="checkbox"/> Continue <input type="checkbox"/> Change <input type="checkbox"/> Monitor <input type="checkbox"/> Work up	

**Care Coordination** (Check all that apply)

**BEHAVIORAL HEALTH**

- Acute case where BH case manager may benefit
- Readmission to BH inpatient or residential treatment center within 30 days
- Two or more admissions to BH inpatient or residential treatment center in 12 months

**CASE MANAGEMENT**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Diabetic with new diagnosis of renal failure            | <input type="checkbox"/> Social/financial   |
| <input type="checkbox"/> Burns, second degree over 19% of body                                      | <input type="checkbox"/> End of life   | <input type="checkbox"/> Transplant   |
| <input type="checkbox"/> Cerebral vascular accident/subarachnoid hemorrhage with cognitive deficits | <input type="checkbox"/> ER visits, three or more in last six months             | <input type="checkbox"/> Trauma, severe multiple (such as motor vehicle accident) |
| <input type="checkbox"/> Chronic obstructive pulmonary disease                                      | <input type="checkbox"/> HIV/AIDS  | <input type="checkbox"/> Traumatic brain injury                                   |
| <input type="checkbox"/> Congestive heart failure   | <input type="checkbox"/> Inpatient admissions, more than three within six months | <input type="checkbox"/> Wound management, complicated                            |
| <input type="checkbox"/> Coronary artery  | <input type="checkbox"/> Inpatient length of stay over 14 days                   | <input type="checkbox"/> Other  |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Medication management                                   | <i>Specify:</i> _____   |
| <input type="checkbox"/> Diabetic with new amputation   | <input type="checkbox"/> Paraplegia/quadruplegia                                 |   |



Patient Last Name, First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_

**Advance Care Planning Services**

Discussed future care decisions: \_\_\_\_\_

Are advance directives (plans around resuscitation, life-sustaining treatment and end-of-life care) in place at this time?  Yes  No

Does the member need assistance completing advance directives?  Yes  No

Encouraged member to inform others about care preferences: \_\_\_\_\_

Explained advance directives (may require completion of standard forms): \_\_\_\_\_

Member did not wish to discuss any of the above at this time

**Additional Measures** (Eligible for both Medicare and Medicaid)

MEASURE	DESCRIPTION	COMPLETED DATE
Functional Status	Assess ability to perform ADLs	
Pain Screening	Screening/pain management plan at least once per year	
Medication Review	Annual review of all medications and supplements	

Personalized health advice with referral (if appropriate) to reduce risk factors, improve self-management and wellness (see Care Coordination table for additional options):

**PROVIDER SIGNATURE**

**PROVIDER CREDENTIALS**

**DATE**

The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.