Annual Care for Older Adults (COA) Form

Read Carefully

This form must be reviewed and signed by the physician or other provider. Please save a copy in the patient's medical records. This form is available online at www.wellcare.com> California> Providers> Medicare> Quality under HEDIS Measurement Year 2022 Toolkit or go directly to www.wellcare.com/en/California/Providers/Medicare/Quality.

Patient Name: _____ DOB: _____ /_____ /_____ ID #: _____

Date Vitals Collected: _____ /_____ /_____ Blood Pressure: _____ /_____

Functional Status Assessment (CPT II: 1170F)

Date Assessed: ___ /___ /___ ADLs Assessed? ☐ Yes ☐ No IADLs Assessed? ☐ Yes ☐ No

Was an FSA tool used: ☐ Yes ☐ No If YES, name of FSA tool _____
Score/Result_____

Pain Assessment (CPT II: 1125F, 1126F)

Date Assessed: _____ /_____ /_____ Does the patient have pain? ☐ Yes ☐ No

Medication List and Review (CPT II: 1159F and 1160F)
Attach the member's medication list OR document all prescriptions, over-the-counter and herbal supplements below.

This section must be reviewed and signed by prescribing provider or clinical pharmacist.

Date Reviewed: _____ /_____ /_____ Medication List attached: ☐

Patient not taking any medications: ☐

Medication/Dosage/Frequency	Medication/Dosage/Frequency

Provider Name (Print): _____

Credentials: ☐ MD ☐ DO ☐ NP ☐ PA ☐ PharmD ☐ Other: _____

Provider Signature: _____Date: _____ /_____ /_____

If the form is filled out by an office or clinical support staff member, it must route back to the provider for follow-up and sign off.

Advance Care Planning (ACP) Form

Read Carefully

This form must be reviewed and signed by the physician or other provider. Please save a copy in the patient's medical records. This form is available online at www.wellcare.com> California> Providers> Medicare> Quality under HEDIS Measurement Year 2022 Toolkit or go directly to www.wellcare.com/en/California/Providers/Medicare/Quality.

Patient Name: _____ DOB: _____ /_____ / _____ ID #: _____

Advance Care Planning (CPT II: 1123F, 1124F, 1157F, 1158F)
Date discussed with Patient/Caregiver: _____ / _____ / _____ **Copy of Advance Care Plan in patient's chart:** ☐ Yes ☐ No Patient has: ☐ Advance Directives ☐ Surrogate Decision Maker ☐ Living Will ☐ Actionable Medical Orders

Provider Name (Print): _____

Credentials: ☐ MD ☐ DO ☐ NP ☐ PA ☐ PharmD ☐ Other: _____

Provider Signature: _____Date: _____ /_____ /_____

If the form is filled out by an office or clinical support staff member, it must route back to the provider for follow-up and sign off.