



GOLD KIDNEY HEALTH PLAN

Annual Wellness Visit Form

Patient Name: _____ **Date of Service:** _____

Date of Birth: _____ **Age:** _____ **Patient ID:** _____

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

General Patient Information

Gender: Male Female Other

Race: American Indian or Alaska Native Asian African American
 Native Hawaiian or other Pacific Islander Caucasian

Are you of Hispanic or Latino origin or descent?

Yes No *If Yes,* Hispanic or Latino

Health Status (in general, how would you rate your overall mental or emotional health?)

Excellent Very Good Good Fair Poor

How many people live in your household now, including yourself?

1 Person 2 to 3 People 4 or more people

Do you have a hearing impairment?

Yes No

Tobacco Usage (Do you now smoke (or chew/snuff) tobacco every day, some days, or not at all?)

Every day* Some days* Not at all

*Please see appendix 1 for information on tobacco cessation.

Alcohol Usage:

Daily Weekly Monthly Never

What is your current marital status?

Married Divorced Separated Widowed Never married

What language do you mainly speak at home?

English Spanish Chinese Russian Other

If Other (please specify): _____

Where do you live?

House, apartment, condominium, or mobile home Nursing home
 Assisted living or board and care home Other

If Other (please specify): _____

Patient Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Patient ID: _____

Vital Signs

Height: _____ Weight: _____ BMI: _____ BP: _____ Pulse 02%: _____

3008F: BMI

Family History

- Adopted – I know my family history
- Adopted – I do NOT know my family history
- N/A

Condition:	Relationship:	Condition:	Relationship:
<input type="checkbox"/> Hypertension	_____	<input type="checkbox"/> Glaucoma	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Alcoholism	_____
<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> Asthma/COPD	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Depression/Suicide	_____
<input type="checkbox"/> Chronic Kidney Disease	_____	<input type="checkbox"/> COVID	_____
Other: _____	_____	Other: _____	_____

Medical History

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Diabetes Mellitus |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> <i>without complications</i> |
| <input type="checkbox"/> Atrial fibrillation | <i>Ejection Fraction:</i> | <input type="checkbox"/> <i>with complications</i> |
| <input type="checkbox"/> Atrial Flutter | <input type="checkbox"/> Constipation | <input type="checkbox"/> <i>with ophthalmic disease</i> |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> COPD | <input type="checkbox"/> <i>with renal disease</i> |
| <input type="checkbox"/> Burn (19% of Body or greater) | <input type="checkbox"/> <i>with exacerbation</i> | <input type="checkbox"/> <i>with neuropathy</i> |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> <i>without exacerbation</i> | <input type="checkbox"/> <i>with PVD</i> |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> <i>long term use of insulin</i> |
| <input type="checkbox"/> Chronic Hepatitis | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> CVA | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> <i>Stage 1 (GFR 90+)</i> | <input type="checkbox"/> Dementia | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> <i>Stage 2 (GFR 60-89)</i> | <input type="checkbox"/> Depression | <input type="checkbox"/> <i>Vertebral</i> |
| <input type="checkbox"/> <i>Stage 3a (GFR 45-59)</i> | <input type="checkbox"/> Drug/Alcohol dependence | <input type="checkbox"/> <i>Femur</i> |
| <input type="checkbox"/> <i>Stage 3b (GFR 30-44)</i> | <input type="checkbox"/> DVT | <input type="checkbox"/> <i>Pelvic</i> |
| <input type="checkbox"/> <i>Stage 4 (GFR 15-29)</i> | | <input type="checkbox"/> <i>Wrist</i> |
| <input type="checkbox"/> <i>Stage 5 (GFR ESRD)</i> | | <input type="checkbox"/> GERD |
| | | <input type="checkbox"/> Head/Spinal Injuries |

Patient Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Patient ID: _____

Medical History *continued*

- | | | |
|---|--|--|
| <input type="checkbox"/> HIV | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Prior Myocardial Infraction |
| <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> PUD |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> PVD |
| <input type="checkbox"/> <i>with CHF</i> | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> <i>with Kidney Disease</i> | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Pituitary Disease | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Malignancy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> SLE |
| <i>Specify:</i> | <input type="checkbox"/> Pressure Ulcer | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Obesity | <i>Site:</i> | |

Surgical History

- | | | |
|---|---|--|
| <input type="checkbox"/> Amputation
<i>Service Date:</i> | <input type="checkbox"/> Cataract surgery
<i>Service Date:</i> | <input type="checkbox"/> Hernia repair
<i>Service Date:</i> |
| <input type="checkbox"/> Appendectomy
<i>Service Date:</i> | <input type="checkbox"/> Cholecystectomy
<i>Service Date:</i> | <input type="checkbox"/> Implantable defibrillator
<i>Service Date:</i> |
| <input type="checkbox"/> Breast biopsy
<i>Service Date:</i> | <input type="checkbox"/> Coronary artery bypass graft
<i>Service Date:</i> | <input type="checkbox"/> Organ transplant
<i>Service Date:</i> |
| <input type="checkbox"/> Carotid endarterectomy
<i>Service Date:</i> | <input type="checkbox"/> Coronary stents
<i>Service Date:</i> | <input type="checkbox"/> Pacemaker
<i>Service Date:</i> |

Other: _____

Medications (list all known medications and supplements)

- | |
|--|
| <input type="checkbox"/> Allergies: |
| <input type="checkbox"/> No known allergies |
| <input type="checkbox"/> Patient does not know |

Provider Initials: _____

Date: _____

Medication Follow-up Questions

Do you have any questions, or are you having any issues with medications you are taking?

Reporting CPT II codes (both codes must be used):

1159F: Medication list documented in medical record | 1160F: Review of all medications by prescriber documented in medical record

Please fax completed form to 1-866-537-0536. Questions? Please reach out to the GKHP Quality Department: quality@goldkidney.com 3

Patient Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Patient ID: _____

Medical Care: List all physicians or suppliers who provided medical care to the patient

Physician Name:	Date:	Condition:

Physician Follow-up Questions

Are you having any issues receiving needed services such as an appointment with a specialist, a referral, etc.?
 Yes No

Are you experiencing any delays, or do you have any questions about the tests, treatments and/or services you are receiving?
 Yes No

ASSESSMENTS

Pain Assessment: Assess level of pain, if present

No Pain Pain Present
 0 1 2 3 4 5 6 7 8 9 10

Location of pain if present: _____

Condition Confirmation

ICD-10 (check all that apply):

- 0521F - Plan of care documented
- 1125F - Pain severity quantified, pain present
- 1126F - Pain severity quantified, no pain present

Condition: _____

Status: Stable Unstable Asymptomatic Symptomatic Unknown

Plan: Continue Change Monitor Workup

Findings: _____

Patient Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Patient ID: _____

Assessments (complete the following assessments)

Physical activity assessment*

Are you having any pain that is limiting your physical activity? How many times a week are you active, with increased heart rate at least 30minutes?

- Start exercise Increase exercise Maintain current level of physical activity

Fall Risk assessment*

Have you had a fall in the past year or are you having any trouble with balance?

- Patient did not have any falls or only had 1 fall in the past year
 Patient had 2 or more falls in the past year

Urinary Incontinence

Have you had any problems controlling your bladder in the past six months?

- Patient is NOT incontinent
 If so how often? When does the problem occur?

Condition Confirmation

ICD-10 (check all that apply):

- 1090F - Urinary incontinence refers to the leakage of urine due to lack of bladder control. The provider assesses a female patient of 65 years or older for the presence or absence of urinary incontinence within a 12-month period.
 1100F - Patient screened for future fall risk.
 1101F - Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year.
 R32 - Unspecified urinary incontinence.
 R39.81 - Functional urinary incontinence.
 F98.0 - Non-organic enuresis.
 N39.3-39.4 - Stress incontinence and other specified urinary incontinence.
 R39.81 - Urinary incontinence associated with cognitive impairment.

Condition: _____

Status: Stable Unstable Asymptomatic Symptomatic Unknown

Plan: Continue Change Monitor Workup

Findings: _____

Patient Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Patient ID: _____

Functional Status Assessment: Select the appropriate answer for each activity list below

Activity	Independent	Needs Some Assistance	Dependent on Others
Bathing <i>Do you have difficulty bathing?</i>	<input type="checkbox"/> Patient can bathe themselves regularly	<input type="checkbox"/> Patient needs handrails in the shower or bathtub	<input type="checkbox"/> Patient needs another person to help them bathe/ shower
Dressing <i>Do you have difficulty dressing?</i>	<input type="checkbox"/> Patient can dress themselves	<input type="checkbox"/> Patient struggles a bit when getting dressed	<input type="checkbox"/> Patient needs someone else to help them get dressed
Eating	<input type="checkbox"/> Patient can eat and prepare food by themselves	<input type="checkbox"/> Patient needs some assistance in preparing or eating food	<input type="checkbox"/> Patient is dependent on others for preparing food and feeding them
Transferring	<input type="checkbox"/> Patient can get in and out of bed without a problem	<input type="checkbox"/> Patient needs the assistance of guard rails to get out of bed	<input type="checkbox"/> Patient needs another person's assistance to get in and out of bed
Walking <i>Do you have serious difficulty walking or climbing stairs?</i>	<input type="checkbox"/> Patient can walk without the use of mobility aids	<input type="checkbox"/> Patient needs mobility aids to walk	<input type="checkbox"/> Patient is wheelchair bound
Toilet	<input type="checkbox"/> Patient can go to the toilet by themselves	<input type="checkbox"/> Patient needs guardrails or grab bars when going to the toilet	<input type="checkbox"/> Patient is dependent on others when going to the toilet

Additional Functional Assessment Question

Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

Yes No N/A

Condition Confirmation

ICD-10 (check all that apply):

1170F - The provider assesses the functional status of a patient with rheumatoid arthritis, or RA. The assessment may evaluate the patient's level of activities of daily living, or ADL, and or status of instrumental activities of daily living, or IADL.

Condition: _____

Status: Stable Unstable Asymptomatic Symptomatic Unknown

Plan: Continue Change Monitor Workup

Findings: _____

Patient Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Patient ID: _____

Patient Health Questionnaire: Select answers that apply to current situation

Over the last two weeks, how often have you been bothered by any of the following problems?

Questions	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down depressed or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Trouble falling or staying asleep or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Trouble concentrating on things such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Thoughts that you would be better off dead, or hurting yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Add Totals: _____

Condition Confirmation

ICD-10 (check all that apply):

- 96160 - The provider administers a questionnaire aimed at helping to identify a specific health risk to a patient, analyzes the results, assigns a score, and documents the findings. Use this code for each standardized survey questionnaire (criteria established and agreed upon by a group of experts).

Condition: _____

Status: Stable Unstable Asymptomatic Symptomatic Unknown

Plan: Continue Change Monitor Workup

Findings: _____

Patient Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Patient ID: _____

Six-Item Cognitive Impairment Test

Questions	Scoring System		
What year is it?	<input type="checkbox"/> Correct (0pts)	<input type="checkbox"/> Incorrect (4pts)	
What month is it?	<input type="checkbox"/> Correct (0pts)	<input type="checkbox"/> Incorrect (3pts)	
Give the patient an address phrase to remember with five components (example John, Doe, 24, sunset Blvd Los Angeles).			
About what time is it within one hour?	<input type="checkbox"/> Correct (0pts)	<input type="checkbox"/> Incorrect (3pts)	
Count backwards from 20 to 1.	<input type="checkbox"/> Correct (0pts)	<input type="checkbox"/> 1 Error (2pts)	<input type="checkbox"/> More than one error (4pts)
Say the months of the year in reverse.	<input type="checkbox"/> Correct (0pts)	<input type="checkbox"/> 1 Error (2pts)	<input type="checkbox"/> More than one error (4pts)
Repeat address phrase.	<input type="checkbox"/> Correct (0pts)	<input type="checkbox"/> 2 Errors (4pts)	<input type="checkbox"/> 4 Errors (8pts)
	<input type="checkbox"/> 1 Error (2pts)	<input type="checkbox"/> 3 Errors (6pts)	<input type="checkbox"/> All wrong (10pts)

Total Score: _____

Scoring: 0-7 normal 8-9 probably significant cognitive impairment (consider referral)
 11-50 significant cognitive impairment (refer)

Condition Confirmation

ICD-10 (check all that apply):

- 96116 - A physician or other qualified healthcare professional performs a face-to-face assessment of a patient's thinking, reasoning, and judgment. Report this code for the first hour of face-to-face clinical assessment as well as the time spent interpreting the results and preparing a report.
- 96125 - In this procedure, the provider performs standardized cognitive performance testing, which is a functional assessment test for a person with memory loss.

Condition: _____

Status: Stable Unstable Asymptomatic Symptomatic Unknown

Plan: Continue Change Monitor Workup

Findings: _____

Patient Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Patient ID: _____

PREVENTATIVE SCREENINGS

Immunization

Influenza Vaccination

Have you had a flu shot since July 1, 2022?

Vaccine administered during today's visit (G0008) Date Completed:

Vaccine administered previously (4037F) Date Completed:

Pneumococcal Vaccination

Have you ever had one or more pneumonia shots? Two shots are usually given in a person's lifetime, and these are different from a flu shot. It is also called the pneumococcal vaccine.

Vaccine administered during today's visit (G0009) Date Completed:

Vaccine administered previously (4040F) Date Completed:

Colorectal Screening and Counseling

Colorectal Cancer Screening

Patients aged 50-75 years must complete any one of the following screenings for colorectal cancer:

Colonoscopy (every 10 years) Date Completed:

Flexible sigmoidoscopy (every 5 years) Date Completed:

CT Colonography (every 5 years) Date Completed:

FIT-DNA (every 3 years) Date Completed:

Fecal Occult Blood Test (every year) Date Completed:

N/A

Condition Confirmation

ICD-10 (check or add any applicable codes):

3017F - Colorectal cancer screening includes radiologic, endoscopic, and laboratory tests to assess the colon, or lower part of the large intestine, and the rectum for cancer in individuals at age 50 or older. The code includes the interpretation of the results of the procedure by the provider and its documentation. Unlike diagnostic tests, there do not need to be signs, symptoms, or history of colon disease in order to cover a screening exam.

82270 - The lab analyst uses a peroxidase activity method to perform a colorectal cancer screening test for the presence of hidden blood in a fecal specimen that the patient collects from three consecutive bowel movements. Clinicians commonly call the test a fecal occult blood test (FOBT).

Condition: _____

Status: Stable Unstable Asymptomatic Symptomatic Unknown

Plan: Continue Change Monitor Workup

Findings: _____

Patient Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Patient ID: _____

Breast Cancer Screening and Counseling

Breast cancer screening **women aged 50-75 years** must complete a mammogram every two years.

- Mammography performed 27 months prior to December 31st period of the current measurement year. Date Completed: _____
- Excluded due to bilateral mastectomy. Date Completed: _____
- Excluded due to two unilateral mastectomies with service dates 14 days or more apart. Date Completed: _____
- Excluded due to unilateral mastectomy with bilateral modifier. Date Completed: _____
- N/A

Condition Confirmation

ICD-10 (*check all that apply*):

- 3315F - The provider assesses the presence of estrogen or progesterone receptors, cell proteins that bind to specific molecules, within tumor cells in female patients, 18 years of age or older. A tumor that is estrogen or progesterone receptor positive (ER+ or PR+) responds to medications that interfere with the production or utilization of estrogen.

Condition: _____

Status: Stable Unstable Asymptomatic Symptomatic Unknown

Plan: Continue Change Monitor Workup

Findings: _____

Cervical Cancer Screening and Counseling

Cervical Cancer

- Women aged 24-64 years** must complete a cervical cytology every 3 years. Date Completed: _____
- Women aged 30-64 years** must complete a cervical high-risk HPV testing every 5 years. Date Completed: _____
- N/A

Condition Confirmation

ICD-10 (*check or add any applicable codes*):

- 3015F - Diagnostic/screening processes.

Condition: _____

Status: Stable Unstable Asymptomatic Symptomatic Unknown

Plan: Continue Change Monitor Workup

Findings: _____

Patient Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Patient ID: _____

Controlling Blood Pressure

Hypertension

Members 18-85 years old whose blood pressure BP was adequately controlled (less than 140/90). BP reading during the current measurement year on or after the second diagnosis of hypertension. Most recent reading in the current measurement year must have a representative systolic BP less than 140 mmHg and a representative diastolic BP less than 90 mmHg. Date Completed: _____

N/A

Condition Confirmation

ICD-10 (circle or add any applicable codes):

- 3074F: SBP \leq 130 mmHg
- 3075F: SBP 130-139 mmHg
- 3077F: SBP \geq 140 mmHg
- 3078F: DBP \leq 80 mmHg
- 3079F: DBP 80-89 mmHg
- 3080F: DBP \geq 90 mmHg

Condition: _____

Status: Stable Unstable Asymptomatic Symptomatic Unknown

Plan: Continue Change Monitor Workup

Findings: _____

Patient Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Patient ID: _____

Diabetes Screening and Counseling

Diabetes Screenings

Diabetic patients aged 18-75 years must complete the following screenings:

- Hemoglobin A1C screening at least once a year. Date Completed: _____
A1C results: A1C less than 7%
 A1C greater than 7% and less than 8%
 A1C greater than 8% and less than 9%
- Dilated or retinal eye exam every year. If patient had a negative result in the year prior, patient may complete eye exam every two years. Date Completed: _____
- Bilateral eye enucleation any time during the member's history or current measurement year. Date Completed: _____
- Micro albumin screening every year. Date Completed: _____
- Foot exam completed by a podiatrist, as needed. Date Completed: _____
- N/A

Condition Confirmation

ICD-10 (check or add any applicable codes):

HbA1C (83036, 83037)

- 3044F $\leq 7.0\%$
 3051F $\geq 7.0\%$ and $\leq 8.0\%$
 3052F $\geq 8.0\%$ and $\leq 9.0\%$
 3046F $\geq 9.0\%$
 uACR (82043)
 Urine Creatine Test (82570)
 eGFR (81000-81005, 82043, 82044)

Reporting CPT II Codes: 2023F, 2025F, or 2033F for negative retinopathy, 2022F, 2024F, or 2026F for positive/unknown

Condition: _____

Status: Stable Unstable Asymptomatic Symptomatic Unknown

Plan: Continue Change Monitor Workup

Findings: _____

Patient Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Patient ID: _____

Kidney Health Evaluation for Patients with Diabetes Screening and Counseling

Kidney Health Evaluation for Patients with Diabetes

- Members 18-85 years old** with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin creatinine ratio (uACR) during the measurement year. Date Completed: _____
- N/A

Condition Confirmation

ICD-10 (check all that apply):

- 90947 - Report 90947 if the procedure requires repeated physician evaluations, with or without substantial revision of a dialysis prescription.

Condition: _____

Status: Stable Unstable Asymptomatic Symptomatic Unknown

Plan: Continue Change Monitor Workup

Findings: _____

Osteoporosis Cancer Screening and Counseling

Osteoporosis Screening

- Women aged 67-85 years** who had a fracture must complete a bone mineral density test or be dispensed osteoporosis medication within six months of the fracture date. Date Completed: _____
- N/A

Condition Confirmation

ICD-10 (check all that apply):

- Z13 - Screening is the testing for disease or disease precursors in asymptomatic individuals so that early detection and treatment can be provided for those who test positive for the disease.
- R54 - Age-related physical debility.

Condition: _____

Status: Stable Unstable Asymptomatic Symptomatic Unknown

Plan: Continue Change Monitor Workup

Findings: _____

Patient Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Patient ID: _____

Statin Therapy Screening and Counseling

Statin Therapy for Cardiovascular Disease

- Patients aged 40-75 years who are diagnosed with CVD must be prescribed with moderate to high intensity statin medication. Date Completed: _____
- N/A

Statin Therapy for Diabetes

- Patients aged 40-75 years who are diagnosed with Diabetes must be prescribed with statin medication. Date Completed: _____
- N/A

Condition Confirmation

ICD-10 (check or add any applicable codes):

- 4013F - A provider uses this code to report that the provider prescribes or the patient is currently taking a statin therapy. Statins are drugs that lower the level of cholesterol in blood as it reduces its production in liver. The provider may adjust the patient's statin therapy depending on his condition.

Condition: _____

Status: Stable Unstable Asymptomatic Symptomatic Unknown

Plan: Continue Change Monitor Workup

Findings: _____

Case Management and Screenings

- Have you been in contact with your case manager?
- Has your case manager discussed screening/prevention for the next five to ten years?
- Inquiry...

Advanced care planning services

- Encourage member to inform others about care preferences and future care decisions
- Explain advanced directives may require completion of standard forms
- Member did not wish to discuss any of the above at this time

Provider Name: _____

Provider Signature: _____ Date: _____

Gold Kidney Health Plan is an HMO, HMO C-SNP, HMO-POS C-SNP with a Medicare contract.
Enrollment in Gold Kidney Health Plan depends on contract renewal.



GOLD KIDNEY HEALTH PLAN

ANNUAL VISIT FORM (AWV) | FREQUENTLY ASKED QUESTIONS

What is the Gold Kidney AWV?

The Gold Kidney Annual Wellness Visit form (AWV) is intended to guide a comprehensive health assessment. The form consists of elements from the Annual Wellness Visit, a physical exam and Healthcare Effectiveness Data and Information Set (HEDIS®) measures. The form can be used by physicians and other healthcare providers to help document vital information for Gold Kidney Medicare Advantage-covered patients during an annual face-to-face examination or telehealth visit. The Gold Kidney AWV is a stand-alone medical record, which should include supporting documentation for all services billed to capture the true health status of the patient.

Why should I complete the AWV?

The AWV serves as a concise template that helps to ensure all the elements of a comprehensive health and quality assessment are documented, while assisting in HEDIS measurement closure.

Completion of the form enhances complete and accurate medical record documentation, which allows diagnosis coding to the highest level of specificity and identifies opportunities to positively impact patient care with HEDIS® and CMS STAR Ratings measures. It will help improve coordination of care and help patients access applicable Gold Kidney Health Plan Care Management programs.

How do I complete the AWV?

- Ensure you are using the most updated AWV form. The current version of the AWV form can be found at www.goldkidney.com/forms/
- Contact your assigned Gold Kidney-covered patient to schedule an appointment.
- Complete the Gold Kidney AWV during a face-to-face encounter between a patient and a licensed medical doctor (MD), doctor of osteopathy (DO), physician assistant (PA) or nurse practitioner (NP).
- Examine, evaluate and treat the patient as you normally would, being sure to assess all of his or her chronic health conditions, if any, as well as any acute conditions that may be present.
- Ensure that the assessment form is completed in its entirety and signed by the rendering healthcare provider.
- Place the completed assessment form in the patient's medical record.
- Submit the completed assessment form to Gold Kidney by faxing all completed forms to the Quality Assurance line at 1-866-537-0536.

Do I have to submit a claim?

A claim must be submitted with Current Procedural Terminology (CPT®) code G0438 for initial visit and G0439 for subsequent visit and/or G0402 for initial preventive physical examination.

If you have additional questions, please contact the Quality Department: quality@goldkidney.com