Devoted HEALTH PLANS

# Annual Care of Older Adults

Use this form to close important gaps in care for our SNP members. You can add the codes provided in each section to a claim for the patient visit. Or send us this completed form in any of the following ways:

- Our Provider Portal (log in at **availity.com**)
- By sFTP (drop it in the Quality->supplemental_data folder)
- By fax to **1-877-420-4662**
- By secure email to **starsandriskmgmt@devoted.com**

## Member Details

| FULL NAME | DATE OF BIRTH | DEVOTED HEALTH MEMBER ID |
|---|---|---|
| | | |

## **Pain Assessment** CPT II: 1125F, 1126F

**Tell us about any pain you've had over the last 7 days**

| | NO PAIN | MILD | MODERATE | SEVERE | VERY SEVERE |
|---|---|---|---|---|---|
| How intense was your pain at its worst? | ☐ | ☐ | ☐ | ☐ | ☐ |
| How intense was your average pain? | ☐ | ☐ | ☐ | ☐ | ☐ |
| What is your level of pain right now? | ☐ | ☐ | ☐ | ☐ | ☐ |

Date Assessed: _____

Provider Name (Print): _____

Provider Signature: _____ Date: _____

## **Functional Status Assessment** CPT II: 1170F

| | YES | NO | UNKNOWN |
|---|---|---|---|
| Are you able to bathe yourself without assistance? | ☐ | ☐ | ☐ |
| Are you able to select clothes from your wardrobe and dress or undress yourself without assistance? | ☐ | ☐ | ☐ |
| Are you able to use the toilet and clean yourself without assistance? | ☐ | ☐ | ☐ |
| Are you able to move in and out of your bed or chair without assistance? | ☐ | ☐ | ☐ |
| Are you able to completely control your urination and defecation? | ☐ | ☐ | ☐ |
| Are you able to eat without assistance? | ☐ | ☐ | ☐ |

Date Assessed: _____

# Medication List and Review

## Medication Review

CPT: 90863, 99605, 99606
CPT II: 1160F

## Medication List

CPT II: 1159F
HCPCS: G8427

| | YES | NO |
|---|---|---|
| **Is the patient taking any medications (prescription, over-the-counter, or herbal)?** | ☐ | ☐ |

Be sure to review all prescriptions, OTC medications, and herbal supplements. The medication review and list must be completed on the same date by a prescribing practitioner or clinical pharmacist.

**Date Reviewed:** _____

**Reviewer Name:** _____ **Credentials:** _____

| MEDICATION | TYPE | DOSE | FREQUENCY | ROUTE | TREATMENT |
|---|---|---|---|---|---|
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