

**❖ Patient Demographics (All Fields Required)**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Advantage MD Member ID: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Gender: M / F

**❖ Provider Information (All Fields Required)**

Provider Name: \_\_\_\_\_ TIN: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_

**❖ Patient Vitals**

BP: \_\_\_\_/\_\_\_\_ Temp: \_\_\_\_ Pulse: \_\_\_\_ Pulse Ox: \_\_\_\_ Wt: \_\_\_\_ Ht: \_\_\_\_  
 BP goal is < 140/90 or <150/90 without diagnosis of diabetes BMI: \_\_\_\_ >40 Morbid Obesity \_\_\_\_

**❖ Preventive Screenings** List all screenings applicable to the patient. The Date of Service for screening is required.

Screenings	Date Complete (MM/YYYY)	Results/Type of Test
<b>Colorectal (check any that apply and provide date completed and result)</b>		
<input type="checkbox"/> Colonoscopy	___/___	_____
<input type="checkbox"/> CT colonography	___/___	_____
<input type="checkbox"/> FIT DNA	___/___	_____
<input type="checkbox"/> Flex sigmoidoscopy	___/___	_____
<input type="checkbox"/> FOBT	___/___	_____
<input type="checkbox"/> History of Colorectal Cancer or Total Colectomy	___/___	_____
Diabetic Eye Exam (completed by) <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optometrist ___/___ <input type="checkbox"/> Retinopathy <input type="checkbox"/> No Retinopathy		
Hemoglobin A1c ___/___ _____		
<b>Mammogram (check any that apply and provide date completed and result)</b>		
<input type="checkbox"/> Bilateral Mammogram	___/___	_____
<input type="checkbox"/> History of Bilateral Mastectomy	___/___	_____
<input type="checkbox"/> Unilateral Mammogram	___/___	_____

Note: Include the results of the screening identified above or within the corresponding progress note.

**❖ Commonly Missed Diagnoses** ALL Potential diagnoses must be addressed by checking associated box.

Checking "diagnosed at Visit/Yes" and Diagnosed at Visit/Referred (to Specialist)" must be submitted with corresponding progress note.

Condition(s), Designate Specificity	Assessed at Visit			N/A
	Yes	No	Referred	
Amputation Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes/Diabetic Complications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Condition(s)(MDD, Bipolar, Schizophrenia, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ostomies (respiration, feeding, or elimination)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transplants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**❖ Form Submission Instructions**

- Attach corresponding detailed progress note signed by rendering provider, with applicable screening results noted.
- Return complete forms with progress notes via fax, Fax Number: (844) 303-1716
- For Whole Health Assessment Form reimbursement, bill G9008
- Any questions regarding the "preventive screening section" please refer to the quality tip sheet

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