Whole Health Assessment Form

ADVANTAGE MD
Johns Hopkins Medicine Medicare Plan

❖ 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
Colorectal *(check any that apply and provide date completed and result)*		
☐ Colonoscopy	___/_____	_____
☐ CT colonography	___/_____	_____
☐ FIT DNA	___/_____	_____
☐ Flex sigmoidoscopy	___/_____	_____
☐ FOBT	___/_____	_____
☐ History of Colorectal Cancer or Total Colectomy	___/_____	_____
Diabetic Eye Exam (completed by) ☐ Opthalmologist ☐ Optometrist	___/_____	☐ Retinopathy ☐ No Retinopathy
Hemoglobin A1c	___/_____	_____
Mammogram (check any that apply and provide date completed and result)		
☐ Bilateral Mammogram	___/_____	_____
☐ History of Bilateral Mastectomy	___/_____	_____
☐ 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: Yes	No	Referred	N/A
Amputation Status	☐	☐	☐	☐
Chronic Lung Disease	☐	☐	☐	☐
Diabetes/Diabetic Complications	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐
Mental Health Condition(s)(MDD, Bipolar, Schizophrenia, etc)	☐	☐	☐	☐
Ostomies (respiration, feeding, or elimination)	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐
Transplants	☐	☐	☐	☐
Vascular Disease	☐	☐	☐	☐
Other:	☐	☐	☐	☐

❖ 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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