Annual Care for Older Adults (COA) Form Page 1

meridiancomplete
A WellCare Company

Please fax completed forms and medical record documentation to 312-508-7213 and save a copy in the patient's medical record. As an alternative method to submit this information, bill the appropriate codes listed below. The COA components may occur during separate visits within the year during an office visit or by phone.

All items in bold must be completed.

Patient Name: _____ **DOB:** _____ **ID #:** _____

Date Vitals Collected: _____/ _____/ _____ **Blood Pressure:** _____/ _____ **Weight:** _____ **lbs. BMI:** _____

Advance Care Planning

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

Medication Review

Date Reviewed: _____/ _____/ _____

Patient taking medications:
☐Yes ☐No

Medication list attached or included on page 2 of Annual COA Form:
☐**Yes** ☐**No**

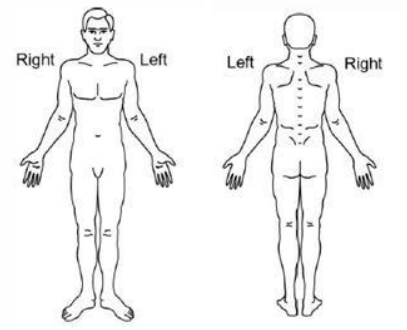
Pain Assessment

Date Assessed: _____/ _____/ _____

Does the patient have pain? ☐**Yes** ☐**No**

Pain is constant: ☐Yes ☐No
Pain limits daily activities: ☐Yes ☐No

Location of Patient's Pain (mark drawing):



Functional Status Assessment

Date Assessed: _____/ _____/ _____

Can the patient perform all activities of daily living (ADL) and instrumental ADLs independently?
☐**Yes** ☐**No**

If NO, patient needs help with:

☐Bathing	☐Shopping	☐Dressing
☐Driving	☐Transferring	☐Housework
☐Meal Prep	☐Feeding/Eating	☐Climbing Stairs
☐Ambulation	☐Using the Toilet	☐Medication Administration

Check the most appropriate:

Cognitive Status:	☐Excellent	☐Good	☐Fair	☐Poor
Ambulation Status:	☐Excellent	☐Good	☐Fair	☐Poor
Hearing:	☐Excellent	☐Good	☐Fair	☐Poor
Vision:	☐Excellent	☐Good	☐Fair	☐Poor
Speech:	☐Excellent	☐Good	☐Fair	☐Poor

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.

Claim Coding:
Advance Care Planning: CPT: 99497 CPT II: 1123F, 1124F, 1157F, 1158F HCPCS: S0257 ICD-10-CM: Z66;
Functional Status Assessment: CPT II: 1170F HCPCS: G0438, G0439; **Pain Assessment**: CPT II 1125F, 1126F;
Medication Review: See page 2

meridiancomplete
A WellCare Company

Please fax completed forms and medical record documentation to 312-508-7213. File in the patient's medical record.
Please note: The medication review and medication list must be on the same date of service.

Claim Coding:
Medication Review: CPT: 90863, 99605, 99606 CPT II: 1160F; **Medication List:** CPT II: 1159F HCPCS: G8427;
Transitional Care Management: CPT: 99495, 99496

Medication List and Review Document all Prescriptions, Over-the-Counter, and Herbal Supplements					
Date:_____		**Patient not taking any medications:** ☐			
Medication	**Type**	**Dose**	**Frequency**	**Route**	**Treatment**