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Patient Name_____Date of Birth _____ Provider_____

Medicare Wellness: Patient Packet

You have scheduled an appointment with _____ on _____ for a:

_____ Medicare's **"Welcome to Medicare" Visit (a.k.a IPPE)** *Medicare Wellness*
(Benefit available 1 time in your first 12 months of enrollment with Medicare Part B)

_____ Medicare's **Annual Wellness Visit** *Medicare Wellness*
(For beneficiaries past their first 12 months of Medicare Part B enrollment and 12 months after a Welcome to Medicare exam, if that was received)

_____ Regular Adult CPX ("physical exam")

- Medicare Part B primary: This service continues to be **non-covered** by original Medicare Part B. Medicare will deny this service and payment will be your responsibility. If you qualify and would prefer to receive one of Medicare's covered Wellness services (i.e., Welcome to Medicare or Annual Wellness Visit), complete the attached forms & questionnaires and present them at the time of your appointment.)
- Medicare Advantage primary (i.e. Medicare Part C / Replacement Plan): Please check with your insurance plan to verify your benefits and coverage for this routine annual physical exam service.

Enclosed you will find the Patient Questionnaire packet required for the covered *Medicare Wellness* services. Please make sure your name and date of birth are on each page.
It includes:
- Materials explaining the *Medicare Wellness* benefits & what to expect
- Health Risk Assessment (HRA) form
- Depression Screening Questionnaire (PHQ-9)
- List of Providers & Suppliers of Healthcare form

Please complete all of the enclosed questionnaires ***prior to your appointment***. Please bring all of the completed questionnaires with you to your appointment and give them to your provider. Your provider will go over these documents as part of your service. If you don't complete it before your appointment, you may be asked to reschedule.

Thank you! We are looking forward to seeing you.

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Medicare Wellness Visits

IMPORTANT: The three Medicare-created *wellness visits* are focused on wellness, risk factor reduction, and prevention. They are **not the same** as a "routine physical checkup" or "routine annual exam". There continues to be **no coverage from Medicare for traditional, age-specific physicals.**

These 3 Medicare-created *wellness visits* are covered by Medicare at 100%, without deductible or coinsurance, as long as the frequency limits are not exceeded

1. "Welcome to Medicare" or IPPE: once per lifetime in the first 12 months of Part B enrollment

2. Annual Wellness Visit, initial: once per lifetime after the first 12 months of Part B enrollment and at least 12 months after a "Welcome to Medicare" visit (if applicable)

3. Annual Wellness Visit, subsequent: once every 12 months, first one at least 12 months after the initial Annual Wellness Visit

These *wellness visits* **do not include** any clinical laboratory tests, but the provider may separately order such tests during one of these visits. All laboratory tests are subject to Medicare's applicable coverage guidelines and frequency limits. Deductible and coinsurance may be applied.

The *wellness visits* **do not include** other routine preventive services that Medicare covers (i.e., Pelvic/Breast exam, Pap smear, Influenza and pneumonia vaccines, smoking cessation counseling, etc.). These services can be provided alongside one of the *wellness visits* and billed separately to Medicare. These services are subject to their own Medicare coverage guidelines and frequency limits. Deductible and coinsurance may be applied.

An additional office visit (E&M) service can be provided alongside one of the *wellness visits* and billed separately to Medicare if it is significant, separate and medically necessary to treat a new or established health problem. This service is subject to its own Medicare coverage guidelines and limitation. Deductible and coinsurance will be applied.

For additional information about any of Medicare's service you can go to Medicare's beneficiary website at www.medicare.gov

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What to expect from your Medicare Wellness Visit	
Elements	**What to expect**
History	Review of your medical and social history: Past medical & surgical history Current medications & supplements Family medical history History of alcohol, tobacco and/or drug use Diet & exercise Anything else the provider deems appropriate
Identifying Risk Factors	You complete standardized screening questions for: Depression Hearing impairment Activities of daily living Fall risk / home safety Provider reviews results to identify possible risk factors
Health Risk Assessment (HRA)	In written form – you self-report information including screening questions in Risk Factor categories, self-assessment of health status, psychosocial risks, behavioral risks, etc.
Problem list & interventions	Establish a list of your risk factors and conditions for which you are being treated or treatment is recommended
Current Providers/ Suppliers	Establish a list of your current providers and suppliers of healthcare
Detection of Cognitive Impairment	Through direct observation and discussion with you and/or your family/caregivers, provider will assess if there is any cognitive impairment
Exam	Obtain the following: Height &Weight & calculate BMI Blood Pressure Visual acuity screen (eye chart) Anything else the provider deems appropriate

Elements	What to expect
Voluntary Advanced Care (end-of-life) Planning	Upon your consent, gather/provide information on advanced directive and end-of-life planning. You can decline to discuss.
Personalized Health Advice	Counseling /education and/or referral for counseling/education aimed at preventing chronic diseases, reducing your identified risk factors, promoting wellness, and improving self-management of your health
Screening/Preventive services schedule	Establish a written screening schedule, covering the next 5-10 years (checklist) of recommended/appropriate covered preventive services Receive a brief written plan (checklist) of recommended/appropriate screening and preventive services that are covered benefits under Medicare

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Medicare Wellness: List of Providers & Suppliers of Healthcare

Patient Name:_____DOB:_____Date:_____

Please list all of your current providers and suppliers of healthcare

Primary Care Physician/provider(s):

Clinic/Provider Name	Location

Specialist(s):

Clinic/Provider Name	Location	Specialty

Alternative medicine providers (i.e., chiropractors, acupuncturists, etc.):

Clinic/Provider Name	Location	Specialty

Preferred pharmacy(s): Name & Location

Pharmacy Name	Location

Dentist:

Dentist Name	Location

Other:

Patient Name _____ Date of Birth _____ Provider _____

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Medicare Wellness: Health Risk Assessment

1. In general, would you say your health is:

___ Excellent___ Very Good ___ Good ___ Fair ___ Poor

2. How have things been going for you during the past 4 weeks?

___ Very well; could hardly be better
___ Pretty well
___ Good and bad parts about equal
___ Pretty bad
___ Very bad; could hardly be worse

3. How confident are you that you can control and manage most of your health problems/issues?

___ Very confident
___ Somewhat confident
___ Not very confident
___ I do not have any health problems

4. How often in the last 4 weeks have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Rarely
Falling or dizzy when standing up					
Sexual problems or concerns					
Trouble eating well					
Teeth or denture problems					
Problems using the telephone					
Tiredness or fatigue					
Problems sleeping					

5. Have you fallen two or more times in the past year? ___ YES ___ NO

6. Are you afraid of falling? Do you feel unsteady? ___ YES ___ NO

7. HOME SAFETY CHECKLIST

Are entrance ways well lit? ___ YES ___ NO
Are sidewalks/entrance ways maintained? ___ YES ___ NO
Is a carbon monoxide detector installed? ___ YES ___ NO
Are smoke detectors installed? ___ YES ___ NO
Are all medicines kept in original containers with original labels intact? ___ YES ___ NO
Do you throw out all unidentified or out-of-date medications? ___ YES ___ NO

8. How often do you have trouble taking medicines the way you have been told to take them?

___ I do not have to take medicine
___ I always take them as directed
___ Sometimes I take them as directed
___ I seldom take them as directed

9. Are you having difficulties driving your car? ___ Yes, often ___ Sometimes ___ No ___ N/A – I do not use a car

10. Do you always fasten your seat belt when you are in a car?
___ Yes, always/usually
___ Yes, sometimes
___ No

11. How often in the last 4 weeks have you experienced the following:

HEARING LOSS SCREENING

	Never	Seldom	Sometimes	Often	Always
Straining to understand conversation					
Trouble hearing in a noisy background					
Misunderstanding what others are saying					

12. During the past 4 weeks how much have you been bothered by feelings of anxiety, depression, irritability or sadness?
___ Not at all ___ Quite a bit ___ Slightly ___ Moderately ___ Extremely

13. During the past 4 weeks, has your physical or emotional health limited your social activities with family and friends?
___ Not at all ___ Quite a bit ___ Slightly ___ Moderately ___ Extremely

14. During the past 4 weeks, how much bodily pains have you generally had?
___ No Pain ___ Very Mild Pain ___ Mild Pain ___ Moderate Pain ___ Severe Pain

15. Do you have someone who is available to help you if you needed or wanted help?
___ Yes, as much as I want / need
___ Yes, some
___ No, not at all

16. Because of any health problems, do you need the help of another person with shopping, preparation of meals, or house work?
___ Yes ___ No

17. Because of any health problems, do you need the help of another person with your personal care needs, such as eating, bathing, dressing, or getting around the house?
___ Yes ___ No

18. Can you handle your own money without help?
___ Yes ___ No

19. During the past 4 weeks, did you exercise for about 20 minutes, 3 or more days a week?
___ Yes, most of the time
___ Yes, some of the time
___ No, I usually do not exercise this much
___ No, I am not currently exercising

20. When you exercise, how intensely to you typically exercise?
___ Light (stretching/slow walking)
___ Moderate (brisk walking)
___ Heavy (jogging/swimming)
___ Very Heavy (running/stair climbing)

21. Are you a smoker/tobacco user?
___ No – never
___ No – former
___ Yes, and I am interested in quitting
___ Yes, but I'm not ready to quit

22. In the past 7 days, on how many days did you drink alcohol? _____ days

23. On days when you drank alcohol, how often did you have 4 or more drinks?
___ Never
___ Once during the week
___ 2-3 times during the week
___ More than 3 times during the week

Thank you for completing this Medicare Wellness Health Risk Assessment.

Provider's Review:
__/__/__ _____ __/__/__ _____
__/__/__ _____ __/__/__ _____
__/__/__ _____ __/__/__ _____

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Patient Health Questionnaire (PHQ – 9)

Patient Name:_____DOB_____ Date_____ **Over the last 2 weeks, how often have you been bothered by any of the following problems?**

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

Add Columns			

Total	

(Healthcare professional: For interpretation of TOTAL please refer to accompanying scoring card)

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

___Not difficult at all
___Somewhat difficult
___Very Difficult
___Extremely Difficult

Provider Initials _____

PHQ-9 Patient Depression Questionnaire

Score Entered into Flow-Sheet _____

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To be completed by physician:
ADVANCE CARE DIRECTIVES

HEALTH ADVICE & REFERRALS

PHYSICIAN SIGNATURE:_____DATE:_____