of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402

# Provider Assessment Form

BlueAdvantage (PPO)SM
BlueEssential (HMO SNP)SM
Please upload to the Quality Care Rewards Tool in Availity® or fax to 1-877-922-2963

**Please complete this entire form**

Prior PAF Reviewed? ☐ Yes ☐ No

| Name: | | Date of birth (DOB): | Assessment date: |
|---|---|---|---|
| ☐ Male ☐ Female | ☐ Married ☐ Single<br>☐ Divorced ☐ Widowed | Spouse/caregiver name: | Member ID: |
| Email address: | | Ethnicity: | Medicare #: |

Does the patient have an advance directive? ☐ Yes ☐ No
If yes, which one(s)? ☐ Living will ☐ Power of attorney ☐ Other:_______________
If no, have advance directives been discussed? ☐ Yes ☐ No

**Allergies** ☐ None

| Name of medication/allergen | Reaction | Name of medication/allergen | Reaction |
|---|---|---|---|
| | | | |
| | | | |

**Hospitalizations Within the Past Year** ☐ None

| Dates | Reason | Date medication reconciliation completed (must be within 30 days of discharge) | Name of provider, prescriber, pharmacist or registered nurse who performed the medication reconciliation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Surgical History** (e.g., tonsillectomy, appendectomy, gallbladder, etc.) ☐ None

| | | |
|---|---|---|
| ☐ Amputation | | |
| ☐ Colostomy | | |
| ☐ Tracheostomy | | |
| ☐ Transplant | | |
| ☐ Other | | |

**Current Medications** (e.g., prescriptions, diet, herbs, vitamins, and/or over-the-counter medications) ☐ None

| Name of medication | Dose/strength | Frequency | Prescriber | Indications |
|---|---|---|---|---|
| | | | | |
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Patient name:______________________ DOB:__________ Assessment date:__________

| Medication Review | | | | |
|---|---|---|---|---|
| Has patient been discharged from an in-patient facility in the past 30 days? ☐Yes ☐ No | | | | |
| Medication list reviewed for: | | | | Specify/expiain |
| ☐Yes | ☐ No | Drug-drug interactions | | |
| ☐Yes | ☐ No | High-risk medications https://www.ncoa.org/resources/updated-beers-criteriaforpotentially-inappropriate-medication-use-in-older-adults/ | | |
| | ☐Yes | ☐ No | Opioids | |
| | ☐Yes | ☐ No | Aspirin | |
| | ☐Yes | ☐ No | Sleeping medication | |
| | ☐Yes | ☐ No | Nausea medication | |
| | ☐Yes | ☐ No | Muscle relaxers | |
| | ☐Yes | ☐ No | Anxiolytics | |

| Physical Exam | | | |
|---|---|---|---|
| Height: Ft:_____ In:______ | Weight: __________ Lbs. | BMI:___________ | ☐ Unable to obtain BMI<br>☐ Blood Pressure: Sys:_______Dias:_______ |

| | Within normal limits (NL) | Abnormal (AB) | Findings/specify AB |
|---|---|---|---|
| General appearance | ☐ NL | ☐ AB | |
| HENT | ☐ NL | ☐ AB | |
| Eyes | ☐ NL | ☐ AB | |
| Cardiovascular | ☐ NL | ☐ AB | |
| Pulmonary | ☐ NL | ☐ AB | |
| Chest/breast | ☐ NL | ☐ AB | |
| Gastrointestinal | ☐ NL | ☐ AB | |
| Lymphatic | ☐ NL | ☐ AB | |
| Musculoskeletal | ☐ NL | ☐ AB | |
| Skin | ☐ NL | ☐ AB | |
| Neurological | ☐ NL | ☐ AB | |
| Genitourinary | ☐ NL | ☐ AB | |
| Other:__________ | ☐ NL | ☐ AB | |

Patient name:______________________________________

| Diagnosis | Active | Resolved |
|---|---|---|
| **Head and Neck** | | |
| Epilepsy or seizure disorder | ☐ | ☐ |
| Severe head injury | ☐ | ☐ |
| Macular degeneration | ☐ | ☐ |
| Other:____________________ | ☐ | ☐ |
| **Cardiovascular** | | |
| Hypertension | ☐ | ☐ |
| With congestive heart failure | ☐ | ☐ |
| With chronic kidney disease, stage___ | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ |
| Atrial fibrillation | ☐ | ☐ |
| Atrial flutter | ☐ | ☐ |
| Cardiomyopathy | ☐ | ☐ |
| Acute myocardial infarction | ☐ | ☐ |
| Coronary artery disease | ☐ | ☐ |
| With stable angina | ☐ | ☐ |
| With unstable angina | ☐ | ☐ |
| Atherosclerosis of extremities with ulceration or gangrene | ☐ | ☐ |
| Cerebrovascular accident | ☐ | ☐ |
| Hemiplegia/hemiparesis | ☐ | ☐ |
| Vascular disease with complications | ☐ | ☐ |
| Vascular disease without complications | ☐ | ☐ |
| Severe hematological disorders | ☐ | ☐ |
| Other:____________________ | ☐ | ☐ |
| **Pulmonary** | | |
| Chronic bronchitis | ☐ | ☐ |
| Chronic obstructive pulmonary disease | ☐ | ☐ |
| Aspiration/specified bacterial pneumonia | ☐ | ☐ |
| Respirator dependence | ☐ | ☐ |
| Cystic fibrosis | ☐ | ☐ |
| Other:____________________ | ☐ | ☐ |
| **Abdomen** | | |
| Cirrhosis | ☐ | ☐ |
| End-stage liver disease | ☐ | ☐ |
| Crohn's disease | ☐ | ☐ |
| Other:____________________ | ☐ | ☐ |
| **Renal** | | |
| Acute renal failure | ☐ | ☐ |
| Chronic kidney disease | ☐ | ☐ |
| Stage:______ | ☐ | ☐ |
| Dialysis status | ☐ | ☐ |
| **Musculoskeletal** | | |
| Fracture (within the past year) | ☐ | ☐ |
| Site:____________________ | ☐ | ☐ |
| Spinal cord disorder/injury | ☐ | ☐ |
| Quadriplegia | ☐ | ☐ |
| Paraplegia | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ |
| Other:____________________ | ☐ | ☐ |

DOB:______________ Assessment date:______________

| Diagnosis | Active | Resolved |
|---|---|---|
| **Skin-Integumentary** | | |
| Pressure ulcer of skin with necrosis through to muscle, tendon or bone | ☐ | ☐ |
| Pressure ulcer of skin with full thickness skin loss | ☐ | ☐ |
| Other:____________________ | ☐ | ☐ |
| **Endocrine** | | |
| Diabetes type: _______ | ☐ | ☐ |
| With chronic kidney disease, stage:______ | ☐ | ☐ |
| With peripheral neuropathy | ☐ | ☐ |
| With peripheral vascular disease | ☐ | ☐ |
| With retinopathy | ☐ | ☐ |
| With other complications | ☐ | ☐ |
| Without complications | ☐ | ☐ |
| Hyperthyroidism | ☐ | ☐ |
| Hypothyroidism | ☐ | ☐ |
| Other:____________________ | ☐ | ☐ |
| **Cancer** | | |
| Brain or nervous system tumors | ☐ | ☐ |
| Breast | ☐ | ☐ |
| Prostate | ☐ | ☐ |
| Bladder | ☐ | ☐ |
| Colorectal | ☐ | ☐ |
| Lymphoma | ☐ | ☐ |
| Leukemia | ☐ | ☐ |
| Acute | ☐ | ☐ |
| Chronic | ☐ | ☐ |
| Lung | ☐ | ☐ |
| Metastatic cancer (specify):______________ | ☐ | ☐ |
| Other:____________________ | ☐ | ☐ |
| **Infectious Diseases** | | |
| HIV | ☐ | ☐ |
| Chronic hepatitis type: ________ | ☐ | ☐ |
| Other:____________________ | ☐ | ☐ |
| **Behavioral Health** | | |
| Dementia | ☐ | ☐ |
| Mild depression | ☐ | ☐ |
| Severe depression | ☐ | ☐ |
| Drug/alcohol psychosis/dependence | ☐ | ☐ |
| Schizophrenia | ☐ | ☐ |
| Other:____________________ | ☐ | ☐ |
| **Other** | | |
| Morbid obesity (BMI ≥ 40) | ☐ | ☐ |
| Malnutrition | ☐ | ☐ |
| Cerebral palsy | ☐ | ☐ |
| Muscular dystrophy | ☐ | ☐ |
| Multiple sclerosis | ☐ | ☐ |
| Parkinson's disease | ☐ | ☐ |
| Huntington's disease | ☐ | ☐ |
| Monoplegia and other paralytic syndromes | ☐ | ☐ |
| Sepsis | ☐ | ☐ |
| | ☐ | ☐ |

Patient name:________________________ DOB:____________ Assessment date:____________

| Diagnosis/Assessment | Treatment Plan |
|---|---|
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |
| | ☐ Medicine ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Diet<br>☐ Other (Specify/Explain)________ |

| Preventive Services | | |
|---|---|---|
| **Breast Cancer Screening** (women age 50–74) | | |
| ☐ Mammogram performed within 27 months prior to Dec. 31 of the current calendar year (attach results if available) | | Date: |
| ☐ **Excluded** due to bilateral mastectomy | | Date: |
| ☐ **Excluded** due to two unilateral mastectomies | Date: | Date: |
| ☐ **Screening not applicable** due to patient being outside the age range or of the male gender | | |
| **Colorectal Cancer Screening** (patients age 50–75) Attach results if available. | | |
| ☐ Colonoscopy performed this calendar year or in the nine years prior | | Date: |
| ☐ CT colonography performed this calendar year or in the four years prior | | Date: |
| ☐ Flexible sigmoidoscopy performed this calendar year or in the four years prior | | Date: |
| ☐ FIT-DNA test performed this calendar year or in the two years prior | | Date: |
| ☐ Fecal occult blood test (FOBT) or FIT test done this calendar year (can't be from a sample given in provider office) | | Date: |
| ☐ **Excluded** due to total colectomy | | Date: |
| ☐ **Excluded** due to diagnosis of colorectal cancer | | Date: |
| ☐ **Screening not applicable** due to patient being outside the age range | | |

Patient name:________________________ DOB:____________ Assessment date:____________

| Condition Management | | | |
|---|---|---|---|
| **Comprehensive Diabetes Care** (diabetic patients age 18–75) | | | |
| ☐ **Excluded** due to diagnosis of gestational diabetes this calendar year or in the previous year | | | Date: |
| ☐ **Excluded** due to diagnosis of steroid-induced diabetes this calendar year or in the previous year | | | Date: |
| ☐ **Screenings not applicable** due to patient being outside the age range or not having diabetes | | | |
| **Nephropathy** | | | |
| ☐ Urine test for albumin or protein | | Result: | Date: |
| ☐ ACE/ARB therapy this calendar year | Medication Name/Dosage: | | Date: |
| ☐ Visit with nephrologist this calendar year | | | Date: |
| ☐ Diagnosis of renal transplant | | | Date: |
| ☐ Diagnosis of stage 4 chronic kidney disease | | | Date: |
| ☐ Diagnosis of end-stage renal disease | | | Date: |
| **Retinal Eye Exam** | | | |
| ☐ Retinal or dilated eye exam by an optometrist or ophthalmologist this calendar year<br>☐ Name of optometry or ophthalmology provider:____________ | | Result: | Date: |
| ☐ Negative retinal or dilated eye exam by an optometrist or ophthalmologist in the previous calendar year<br>☐ Name of optometry or ophthalmology provider:____________ | | | Date: |
| ☐ Bilateral eye enucleation anytime in the patient's history | | | Date: |
| **HbA1c** | | | |
| ☐ HbA1c test this calendar year | | Result: | Date: |
| **Statin Use** | | | |
| ☐ Medication prescribed (name and dosage): ____________ | | | Date: |
| **Osteoporosis Management in Women With a Fracture** (women age 67–85 with fracture in the past year, excluding fractures of finger, toe, face and skull) | | | |
| Fracture date: ____________ | | | |
| ☐ Bone mineral density testing completed within six months after the fracture | | | Date: |
| ☐ Osteoporosis medication prescribed or taken within six months after the fracture | | | Date: |
| ☐ **Excluded** due to bone mineral density testing being completed within 24 months prior to the fracture | | | Date: |
| ☐ **Excluded** due to osteoporosis therapy within 12 months prior to the fracture | | | Date: |
| ☐ **Screening not applicable** due to patient being outside the age range or not having a fracture | | | |
| **Rheumatoid Arthritis** (patients with diagnosis of rheumatoid arthritis) | | | |
| ☐ Prescribed DMARD treatment this calendar year. Name of medication:____________ | | | Date: |
| ☐ **Excluded** due to pregnancy this calendar year | | | Date: |
| ☐ **Excluded** due to diagnosis of HIV | | | Date: |
| ☐ Diagnosis **not substantiated** | | | |
| ☐ **Screening not applicable** due to having no diagnosis of rheumatoid arthritis | | | |
| **Additional Tests** | | | |
| ☐ Prostate cancer screening | | | Date: |
| ☐ Pap smear/pelvic exam (age 21–65) | | Result: | Date: |
| ☐ Other:____________ | | | Date: |

| Current Vaccinations | |
|---|---|
| ☐ Influenza: Last date:__________ | ☐ Pneumococcal: ☐ PCV13/Prevnar®: Date:__________ ☐ PPSV23/Pneumovax®: Date:__________ |
| ☐ Shingles: ☐ Zostavax®: Date:__________ | ☐ SHINGRIX: Date of first dose: __________ Date of second dose: __________ |
| ☐ Hep C: Date:__________ Result:__________ | ☐ Hep C Treatment: __________ |

Patient name:______________________________ DOB:____________ Assessment date:____________

| Social History | | | | | |
|---|---|---|---|---|---|
| ☐ Yes | ☐ No | Does patient exercise? If yes, how often?__________ Type of exercise:______________ | | | |
| ☐ Yes | ☐ No | Does patient drink alcohol? If yes, how much?__________ Type of alcohol:____________ | | | |
| ☐ Yes | ☐ No | Does patient drink caffeine? If yes, how much?__________ | | | |
| ☐ Yes | ☐ No | Does patient currently use tobacco?<br>If yes: # of years used:______ Type of tobacco: ☐ Cigarettes ☐ Chew ☐ Pipe ☐ Cigar Quantity:__________<br>If no: ☐ Never used ☐ Quit Year patient quit:________ Length of time patient used prior to quitting:__________ | | | |
| ☐ Yes | ☐ No | Does patient use illegal drugs or drugs for which they were not prescribed?<br>If yes: Type:____________ How used:______________ # of years using:______ | | | |
| ☐ Yes | ☐ No | If patient has more than one sexual partner, do they use protection against sexually transmitted infections? | | | |
| ☐ Yes | ☐ No | Does patient use shared needles? | ☐ Yes | ☐ No | Has patient received a blood transfusion or tattoo before 1985? |
| ☐ Yes | ☐ No | Does patient wear a seatbelt? | ☐ Yes | ☐ No | Can patient read and/or write? |
| ☐ Yes | ☐ No | Does patient live alone? | ☐ Yes | ☐ No | Does patient have caregiver or family support to assist with ADLs? |
| ☐ Yes | ☐ No | Has a vision assessment been completed? | ☐ Yes | ☐ No | Is patient blind, or do they have severe vision impairment? |
| ☐ Yes | ☐ No | Has a hearing assessment been completed? | ☐ Yes | ☐ No | Does patient have a hearing impairment?<br>If yes, does patient wear a hearing aid? ☐ Yes ☐ No |

| Other Specialist Providers Caring for This Patient | | | |
|---|---|---|---|
| Name | Specialty | Name | Specialty |
| | | | |
| | | | |
| | | | |

**Functional Status Assessment**

Please select if any of the following assessments have been completed:

☐ Assessment of the following basic activities of daily living (ADLs) such as bathing, dressing, eating, transferring, using toilet, walking

☐ Assessment of the following instrumental ADLs such as meal preparation, shopping for groceries, using public transportation, housework, home repair, laundry, taking medications or handling finances

☐ Results using a standardized functional status assessment tool Name of tool: ______________________

☐ Assessment of three of the following four components: cognitive status; ambulation status; sensory ability; other functional independence, such as exercise, ability to perform job

| Fall Risk Assessment | | | Depression Screening | | |
|---|---|---|---|---|---|
| ☐ Yes | ☐ No | Has a fall risk assessment been completed? | ☐ Yes | ☐ No | Has a depression screening been completed? |
| If yes, tool used: ☐ STEADI ☐ Morse Fall Risk Assessment<br>☐ Hendrich Fall Risk Assessment ☐ Other: __________<br>Results:____________ | | | If yes, tool used: ☐ PHQ-2 ☐ PHQ-9 ☐ Other: ______________<br>Results:____________________ | | |

**Note:** assessment/screening tools are available under the Medicare Quality Care Initiatives section at https://provider.bcbst.com/tools-resources/documents-forms. Attach results/tools used, if available.

| Urinary Incontinence | | |
|---|---|---|
| ☐ Yes | ☐ No | Has patient been screened for urinary incontinence? Results ______________________ |
| ☐ Yes | ☐ No | If patient is positive for bladder control problems, have treatment options such as bladder training exercises, medication or surgery been discussed with the patient? |

**Healthy Days Measurement**

In the past 30 days, how many days was physical health (including physical illness and injury) not good?

☐ 1-4 days ☐ 5-14 days ☐ 15-30 days ☐ none

In the past 30 days, how many days did physical or mental health interrupt usual activities, such as self-care, work or recreation?

☐ 1-4 days ☐ 5-14 days ☐ 15-30 days ☐ none

Patient name:______________________ DOB:__________ Assessment date:__________

| Pain Assessment | | |
|---|---|---|
| ☐Yes | ☐ No | Does patient suffer from pain? ☐ Acute ☐ Chronic |
| If yes, where is the pain located? ______________ | | Is patient in pain management? ☐Yes ☐ No |
| How does patient rate their pain? (Zero is no pain; 10 is extreme pain.)<br>☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 | | |

| Cognitive Assessment | | |
|---|---|---|
| ☐Yes | ☐ No | Has a cognitive assessment been completed? |
| If yes, tool used: ☐ Mini-Cog ☐ GPCOG ☐ MIS ☐ Other: ______________<br>Results:______________ | | |
| **Note**: a cognitive assessment tool is available under the Medicare Quality Care Initiatives section at https://provider.bcbst.com/working-with-us/quality-initiatives. Attach results/tool from assessment if available. | | |

**Please complete this section if you think your patient would benefit from Case Management.**

| Medical Case Management | | |
|---|---|---|
| ☐ | Refer patient to BlueCross for medical case management. | Reason: ______________ |

| Behavioral Health Case Management | | |
|---|---|---|
| ☐ | Refer patient to BlueCross for behavioral health case management. | Reason: ______________ |

| Preventive health plan for next year: |
|---|
| |

Provider Name and Credentials (printed):______________________ Date: __________

Provider Signature:______________________ NPI: __________

*(Please note: This form must be completed and signed by MD, DO, PA or NP and included in the patient's medical record.)*

**Submit this form by uploading it to the Quality Care Rewards tool in Availity or faxing it to 1-877-922-2963. File your claim within 30 days of the visit using CPT® code 96160.**

# PATIENT HEALTH QUESTIONNAIRE-9
# (PHQ-9)

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)* | Not at all | Several Days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling asleep or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself – or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could 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 |
| **9.** Thought that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING ___0___ + ________ + ________ + ________

= TOTAL SCORE: __________

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 |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |