Humana Practitioner Assessment Form

Please fill in the information requested in this box only. Your physician will complete the remaining sections of this assessment.

Patient name: _____ **Date of service:** ____/____/_____

Humana member ID: _____ **Date of birth:** ____/____/_____ **Gender:** ☐ Male ☐ Female

Race/ethnicity: ☐ Hispanic/Latino ☐ American Indian ☐ Alaska Native ☐ Black/African American ☐ African ☐ Asian ☐ Asian Indian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White/Caucasian ☐ Other_____

Medical history – If marked as "active," please also document condition in final diagnosis list.

Diagnosis	Description/remarks	Active/resolved

Providers regularly involved with care — specialists/suppliers

_____ _____

_____ _____

Surgical history

Procedure	Reason for procedure	Date	Surgeon or facility

Current medications – Including over-the-counter medications

Name of medication	Dose/frequency	Conditions being treated

Medical allergies

_____

_____

_____

Patient name: _____ **Date of service:** ____/____/_____

Humana member ID: _____ **Date of birth:** ____/____/_____

Social history	Remarks	Social history	Remarks
Alcohol/drug use		Sexual history	
Tobacco use		High-risk lifestyle	
Diet		Physical Activity	

Family history	Father	Mother	Children	Siblings	Grandparents
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐

Vitals

Height: _____ feet _____ inches **Weight:** _____ pounds

Heart rate: _____ **Blood pressure:** _____/_____

BMI: _____ BMI not completed due to pregnancy ☐ Y ☐ N

Physical examination

	Within normal limits	Abnormal	Findings		Within normal limits	Abnormal	Findings
General appearance	☐	☐		Musculoskeletal	☐	☐	
HEENT	☐	☐		Skin	☐	☐	
Cardiovascular	☐	☐		Neurological	☐	☐	
Respiratory	☐	☐		Genitourinary	☐	☐	
Gastrointestinal	☐	☐		Other	☐	☐	
Hematologic/ lymphatic/immuno	☐	☐					

Additional comments:

Cognitive impairment

1. Ask patient to remember the following three words, and ask the patient to repeat the words to ensure the learning was correct.

   BANANA SUNRISE CHAIR

2. Ask patient to draw a clock. After numbers are on the face, ask patient to draw hands to read 20 minutes after 8 (or 10 minutes after 11).
3. Ask the patient to repeat the three words given previously. _____ _____ _____

Scoring instructions for recalled words and clock drawing test (CDT)		Results (circle one)
3 recalled words or 1-2 recalled words + normal CDT	**Negative** for cognitive impairment	Patient is **negative/positive** for cognitive impairment
1-2 recalled words + abnormal CDT or 0 recalled words	**Positive** for cognitive impairment	Additional comments: _____

Cancer screening – Please fill in all appropriate dates for screening received; only **ONE** is needed to meet HEDIS measures under each section.

Breast cancer screening

Screening not applicable ☐ If checked, move to next section

Mammography performed 27 months prior to Dec. 31 of the current measurement year ____/____/_____

Excluded due to bilateral mastectomy ____/____/_____

Excluded due to two unilateral mastectomies with service dates 14 days or more apart ____/____/_____ and ____/____/_____

Excluded due to unilateral mastectomy with bilateral modifier ____/____/_____

Excluded due to unilateral mastectomy code with right side modifier and a unilateral mastectomy with a left side modifier on the same or different date of service ____/____/_____ ____/____/_____

Patient name: _____ **Date of service:** ____/____/____

Humana member ID: _____ **Date of birth:** ____/____/____

Cancer screening – Please fill in all appropriate dates for screening received; only **ONE** is needed to meet HEDIS measures under each section.

Colorectal cancer screening

Colonoscopy performed in current measurement year or nine previous measurement years	____/____/____
CT Colonography performed in current measurement year or four previous years	____/____/____
Flexible sigmoidoscopy performed in current measurement year or four previous measurement years	____/____/____
FIT-DNA Test performed in current measurement year or two previous measurement years	____/____/____
Fecal occult blood test (FOBT) performed in current measurement year	____/____/____
Excluded due to total colectomy	____/____/____
Excluded due to diagnosis of colorectal cancer	____/____/____

Disease-specific management

Diabetic nephropathy

Screening not applicable ☐ If checked, move to next section

Nephropathy screening: microalbumin test during calendar year	____/____/____	Result: _____
Nephropathy screening: macroalbumin test during calendar year	____/____/____	
Is patient taking angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) during calendar year?	____/____/____	☐Yes ☐No Medication: _____

Nephrologist visit during calendar year: ☐Yes ____/____/____ ☐No Renal transplant? ☐Yes ____/____/____ ☐No

Diabetic eye care — Name of eye care professional

Screening not applicable ☐ If checked, move to next section

Retinal or dilated eye exam by an eye care professional during current measurement year	____/____/____	_____
Negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional during last measurement year	____/____/____	_____
Excluded due to diagnosis of gestational diabetes during past two calendar years	____/____/____	_____
Excluded due to diagnosis of steroid-induced diabetes during past two calendar years	____/____/____	_____

Labs/pathology — Test result

Lab not applicable ☐ If checked, move to next section

HbA1c for patients with diabetes	____/____/____	_____
Excluded due to diagnosis of gestational diabetes in past two calendar years	____/____/____	
Excluded due to diagnosis of steroid-induced diabetes in past two calendar years	____/____/____	

Rheumatoid arthritis (RA) management — Medication name

Diagnosis for RA not verified ☐ If checked, move to next section

Prescribed or current disease-modifying antirheumatic drug (DMARD) during current measurement year	____/____/_____	_____
Excluded due to pregnancy during calendar year	____/____/_____	
Excluded due to diagnosis of HIV positive	____/____/_____	

Patient name: _____ **Date of service:** ____/____/_____

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Disease-specific management – Please fill in all appropriate dates for screening received; only **ONE** is needed to meet HEDIS measures under each section.

Osteoporosis management in women who had a fracture **Medication name**

Screening not applicable ☐ If checked, move to next section

Osteoporosis medication was prescribed or currently taken within six months after the fracture ____/____/_____ _____

Bone mineral density test completed within six months after the fracture ____/____/_____

Excluded due to bone mineral density testing within 24 months prior to fracture ____/____/_____

Excluded due to osteoporosis therapy within the 12 months prior to the fracture ____/____/_____

Excluded due to patient receiving osteoporosis prescription within 12 months prior to fracture ____/____/_____

Immunizations

☐ Influenza virus vaccine — annually ___/___/___

Pneumococcal vaccine — two recommended in lifetime ☐ PCV13 ____/____/_____ ☐ PPSV23 ____/____/_____

☐ Other _____ ____/____/____

Screening assessments

Pain screening – Circle the level of pain patient is in on a daily basis.

☺ **0….1….2….3….4….5….6….7….8….9….10** ☹ ☐ If pain, evidence of pain management

No pain **Moderate pain** **Extreme pain**

Functional status assessment

☐ Assessment of instrumental activities of daily living (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

☐ Assessment of ADLs such as bathing, dressing, eating, transferring, using toilet, walking

Other assessments

☐ Physical activity assessment ☐ Advance directive (Living will Yes/No) ☐ Aspirin use discussion ☐ Medication review for potentially harmful drug-disease interactions in the elderly, such as:

☐ Fall risk assessment ☐ Depression screening _____

Diagnosis – Please provide the appropriate active diagnoses and corresponding codes.

	Diagnosis	ICD-10 code	Circle treatment plan
1.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
2.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
3.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
4.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
5.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
6.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
7.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
8.	_____	_____	Medication/monitor/diet/labs/referrals/other _____

Patient name: _____ **Date of service:** ____/____/____

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Diagnosis — Continued

Diagnosis	ICD-10 code	Circle treatment plan
9. _____	_____	Medication/monitor/diet/labs/referrals/other _____
10. _____	_____	Medication/monitor/diet/labs/referrals/other _____
11. _____	_____	Medication/monitor/diet/labs/referrals/other _____
12. _____	_____	Medication/monitor/diet/labs/referrals/other _____
13. _____	_____	Medication/monitor/diet/labs/referrals/other _____
14. _____	_____	Medication/monitor/diet/labs/referrals/other _____
15. _____	_____	Medication/monitor/diet/labs/referrals/other _____
16. _____	_____	Medication/monitor/diet/labs/referrals/other _____
17. _____	_____	Medication/monitor/diet/labs/referrals/other _____
18. _____	_____	Medication/monitor/diet/labs/referrals/other _____
19. _____	_____	Medication/monitor/diet/labs/referrals/other _____
20. _____	_____	Medication/monitor/diet/labs/referrals/other _____

Screening/prevention plan for the next five to 10 years

Follow-up/referral/test ordered

Assessment statement:

Health care provider acknowledges and agrees that Humana will update and adjust this form as necessary. Updated forms will be available for use in the secure section of Humana's website, http://www.Humana.com/providers/.

Medicare payment to Medicare Advantage organizations is based, in part, on each patient's diagnoses, as attested to by the patient's attending health care provider by virtue of his or her signature on this medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds may be subject to a fine, imprisonment or civil penalty under applicable federal laws.

By signing this document, you attest to having reviewed the medical documents to complete the form using the best of your medical knowledge, having placed the completed original of this form in the patient's medical record and having ensured fully documented proof of service of all completed fields is contained in the patient's medical record. (Note: If the practice has an electronic medical record system, scan the assessment and attach the image to the electronic record.)

To the best of my knowledge, information and belief, the information provided regarding diagnoses is truthful and accurate.

Health care provider name and credentials (printed) | Health care provider signature and credentials (signed) | Date

Provider office number: ( ) -

Billing health care provider ID: Provider type: ☐ TIN ☐ NPI

Health care provider address:

City, state, ZIP: