**Date:**

**Supplemental Clinical Documentation Improvement**

|  |  |  |  |
| --- | --- | --- | --- |
| **Provider Name:** | @ProviderName@ | **NPI:** | @ProviderNPI@ |

**Patient Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** | @Patient-Name@ | **DOB:** | @BirthDay@ |
| **HF ID:** | @HealthfirstID@ | **HICN:** | @HICN@ |

Plan Type: Medicare

**Date of service:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have a drug allergy? Yes  No

If yes, list the medication(s):

Medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vitals for this visit:

Patient’s Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s blood pressure: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Patient’s BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnosis Codes**

**All previously known un-coded/suspected chronic conditions:**

Please verify if the below Chronic conditions remain active in the current year by checking off the applicable boxes next to the condition. If present, your note must support the diagnosis and must be on the visit claim.  Any Cancer related conditions (if active) should be entered on a blank line, documented in your visit note and entered on the claim.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Chronic Conditions:** | **Present in 2017** | **Present in 2018/ Confirmed** | **No longer present** | **Related Condition Exist**  (Please list below) |
| @HCC+Description1@ | @Chekmark1@ |  |  | @Diagcod1@1 |
| @HCC+Description1@ | @Chekmark1@ |  |  | @Diagcod1@2 |
| @HCC+Description1@ | @Chekmark1@ |  |  | Free Text: |
| @HCC+Description2@ | @Chekmark2@ |  |  | @Diagcod2@1 |
| @HCC+Description2@ | @Chekmark2@ |  |  | @Diagcod2@2 |
| @HCC+Description2@ | @Chekmark2@ |  |  | Free Text: |
| @HCC+Description3@ | @Chekmark3@ |  |  | @Diagcod3@1 |
| @HCC+Description3@ | @Chekmark3@ |  |  | @Diagcod3@2 |
| @HCC+Description3@ | @Chekmark3@ |  |  | Free Text: |
| @HCC+Description4@ | @Chekmark4@ |  |  | @Diagcod4@1 |
| @HCC+Description4@ | @Chekmark4@ |  |  | @Diagcod4@2 |
| @HCC+Description4@ | @Chekmark4@ |  |  | Free Text: |
| @HCC+Description5@ | @Chekmark5@ |  |  | @Diagcod5@1 |
| @HCC+Description5@ | @Chekmark5@ |  |  | @Diagcod5@2 |
| @HCC+Description5@ | @Chekmark5@ |  |  | Free Text: |
| @HCC+Description6@ | @Chekmark6@ |  |  | @Diagcod6@1 |
| @HCC+Description6@ | @Chekmark6@ |  |  | @Diagcod6@2 |
| @HCC+Description6@ | @Chekmark6@ |  |  | Free Text: |
| @HCC+Description7@ | @Chekmark7@ |  |  | @Diagcod7@1 |
| @HCC+Description7@ | @Chekmark7@ |  |  | @Diagcod7@2 |
| @HCC+Description7@ | @Chekmark7@ |  |  | Free Text: |
| @HCC+Description8@ | @Chekmark8@ |  |  | @Diagcod8@1 |
| @HCC+Description8@ | @Chekmark8@ |  |  | @Diagcod8@2 |
| @HCC+Description8@ | @Chekmark8@ |  |  | Free Text: |
| @HCC+Description9@ | @Chekmark9@ |  |  | @Diagcod9@1 |
| @HCC+Description9@ | @Chekmark9@ |  |  | @Diagcod9@2 |
| @HCC+Description9@ | @Chekmark9@ |  |  | Free Text: |
| @HCC+Description10@ | @Chekmark10@ |  |  | @Diagcod10@1 |
| @HCC+Description10@ | @Chekmark10@ |  |  | @Diagcod10@2 |
| @HCC+Description10@ | @Chekmark10@ |  |  | Free Text: |

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list the applicable E&M CPT code for this visit:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**