

## 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.

## **\*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](http://www.medicare.gov)

## 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 \_\_\_\_\_ GWY# \_\_\_\_\_ Provider \_\_\_\_\_

**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  
 Some what 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	Always
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

Straining to understand conversation  
 Trouble hearing in a noisy background  
 Misunderstanding what others are saying

Never	Seldom	Sometimes	Often	Always

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:

/	/	/	/	/	/	/	/	/	/
/	/	/	/	/	/	/	/	/	/
/	/	/	/	/	/	/	/	/	/

**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			
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Total	
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*(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 \_\_\_\_\_

## What to expect from your Medicare Wellness Visit

Elements	What to expect
<b>History</b>	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
<b>Identifying Risk Factors</b>	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
<b>Health Risk Assessment (HRA)</b>	In written form – you self-report information including screening questions in Risk Factor categories, self-assessment of health status, psychosocial risks, behavioral risks, etc.
<b>Problem list &amp; interventions</b>	Establish a list of your risk factors and conditions for which you are being treated or treatment is recommended
<b>Current Providers/ Suppliers</b>	Establish a list of your current providers and suppliers of healthcare
<b>Detection of Cognitive Impairment</b>	Through direct observation and discussion with you and/or your family/caregivers, provider will assess if there is any cognitive impairment
<b>Exam</b>	Obtain the following: Height & Weight & calculate BMI Blood Pressure Visual acuity screen (eye chart) Anything else the provider deems appropriate



<b>Elements</b>	<b>What to expect</b>
<b>Voluntary Advanced Care (end-of-life) Planning</b>	Upon your consent, gather/provide information on advanced directive and end-of-life planning. You can decline to discuss.
<b>Personalized Health Advice</b>	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
<b>Screening/Preventive services schedule</b>	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