



Practitioner Assessment Form (PAF)

What is the PAF?

The practitioner assessment form is a health assessment designed to assist the physician in collecting specific information on Medicare Advantage patients. The PAF is intended to be completed annually during a face-to-face visit with the patient.

Why should I fill this out?

- The PAF will help decrease the number of charts Humana requests from your office for annual reporting related to Healthcare Effectiveness Data and Information Set (HEDIS®) and Medicare risk adjustment.
- Completion of the form will help improve coordination of care.

How do I complete this?

- The assessment must be completed during a face-to-face encounter between a doctor and the patient.
- If your assigned or attributed Humana-covered patient is not currently scheduled for an exam this year, please contact him or her to schedule an appointment.
- Examine, evaluate and treat the patient as you normally would, being sure to assess all of his or her chronic health conditions, if any, as well as any acute conditions that may be present.
- Ensure that the assessment form is completed in its entirety and signed by the physician.
- Place the original completed assessment form 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.)
- Please note that the PAF may need to be updated from time to time.
- Updated versions can be found at <http://www.humana.com/providers/>.
- Submit the completed assessment to Humana by one of the two available options. (See enclosed instructions.)
- If you have questions about this report, please contact our centralized provider relations reporting information line at 1-800-626-2741.

Should I submit a claim?

- Yes, a claim should be submitted for all completed PAF submissions.
- The PAF should be submitted with CPT code 99420 along with one of the following visit codes:
 - 99201-99215 — routine physician visit
 - G0402 — Welcome to Medicare exam
 - G0438 or G0439 — annual wellness visit
 - 99381-99397 — annual preventive examIf CPT code 99420 and a visit code are submitted together, a modifier isn't needed.
- In most cases, if services other than the codes shown above are billed with the 99420 PAF code, a -25 modifier needs to be included. Please adhere to all correct coding guidelines when applying a modifier.

Patient name: _____

Date of service: ___/___/___

Humana member ID: _____

Date of birth: ___/___/___

Medical allergies

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	Vitals
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Height: _____ feet _____ inches Weight: _____ pounds
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart rate: _____ Blood pressure: _____/_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BMI: _____ BMI not completed <input type="checkbox"/> Y
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	due to pregnancy

Physical examination

	Within normal limits	Abnormal	Findings		Within normal limits	Abnormal	Findings
General appearance	<input type="checkbox"/>	<input type="checkbox"/>		Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
HEENT	<input type="checkbox"/>	<input type="checkbox"/>		Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>		Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>		Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>	
Hematologic/ lymphatic/immuno	<input type="checkbox"/>	<input type="checkbox"/>					

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
1-2 recalled words + abnormal CDT or 0 recalled words	Positive for cognitive impairment

Patient is **negative/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 _____/_____/_____

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.

Breast cancer screening — continued

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 _____/_____/_____

Colorectal cancer screening

Colonoscopy performed in current measurement year or nine previous measurement years _____/_____/_____

Flexible sigmoidoscopy performed in current measurement year or four 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 _____/_____/_____ _____

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: ___/___/___

Humana member ID: _____ Date of birth: ___/___/___

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 member 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 Urinary incontinence 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: ___/___/___

Humana member ID: _____

Date of birth: ___/___/___

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: _____ () - _____	Provider type: <input type="checkbox"/> TIN <input type="checkbox"/> NPI	
Billing health care provider ID: _____		
Health care provider address: _____		
City, state, ZIP: _____		



How to Submit the Practitioner Assessment Form

Method 1: Electronic medical record

Upload electronic medical records directly to Humana using the fast and secure provider portal with the following steps:

1. Go to www.submitrecords.com/humana and enter the secure password **hfpaf83**.
2. Click the “Add files” button and choose the medical records from your Internet browser.
3. Upload single records in either a PDF or TIFF format. You can batch upload a ZIP file of all records in either a PDF or TIFF format.
4. Add any information regarding the record(s) into the note section. You can add records to a maximum of 100MB of space per upload.
5. Click “Upload” and the selected medical records will be electronically routed to the Humana repository system.

For technical assistance with the provider upload portal, please call 1-801-984-4540. Records will be stored in the secure Humana repository system. The website www.submitrecords.com/humana has been verified by Entrust[®], an identity-based security software provider. All transactions are protected by 128-bit secure sockets layer (SSL).

Method 2: Fax

If you do not have online capabilities, you may fax medical records and/or completed forms to Humana medical record retrieval at 1-888-838-2236. Please use a cover page and ensure that page does not contain any personal health information.