Annual Comprehensive Exam

FAX COMPLETED FORM TO: 877-682-2216

Patient Personal Information

Member Name:		**PCP Name:**	
Date of Birth:	**Age:**	**Sex:**	**Case ID:**
HIC#:	**State:**	**Date Of Service:**	________________
MRN#:		**Member Phone#:**	

Never Existed, Resolved or Unable to Make Diagnosis Conditions

1. Based on the HCC History or List of Suspect Conditions on the “Member Information Profile” sheet the following conditions have either Never Existed, Resolved or a diagnosis cannot be made. Please indicate condition and check mark if the condition Never Existed, is Resolved and the approximate date resolved, or if a diagnosis cannot be made and the reason a diagnosis cannot be made. All pertinent fields must be completed.

A. Condition: ________________________________
- ☐ Never Existed
- ☐ Resolved. Approximate Date Resolved (month/year): _________
- ☐ Unable to Determine Diagnosis. Explain why diagnosis cannot be made:____

B. Condition: ________________________________
- ☐ Never Existed
- ☐ Resolved. Approximate Date Resolved (month/year): _________
- ☐ Unable to Determine Diagnosis. Explain why diagnosis cannot be made:____

C. Condition: ________________________________
- ☐ Never Existed
- ☐ Resolved. Approximate Date Resolved (month/year): _________
- ☐ Unable to Determine Diagnosis. Explain why diagnosis cannot be made:____

D. Condition: ________________________________
- ☐ Never Existed
- ☐ Resolved. Approximate Date Resolved (month/year): _________
- ☐ Unable to Determine Diagnosis. Explain why diagnosis cannot be made:____

E. Condition: ________________________________
- ☐ Never Existed
- ☐ Resolved. Approximate Date Resolved (month/year): _________
- ☐ Unable to Determine Diagnosis. Explain why diagnosis cannot be made:____

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2. For each family of conditions listed under "List of Suspect Conditions" that is neither documented on the ACE form as a diagnosed condition OR documented on the "Never Existed and Resolved Conditions", please confirm the "List of Suspect Conditions" was reviewed. Yes, must be chosen in order to receive payment for the ACE Form in order to show that a comprehensive exam was performed.

[ ] Yes **[ ] No**

COMPLETED BY* (only fields marked with an * are required to be completed):

Provider warrants that by signing below, all the information contained in this document is truthful and accurate.

Mark credential*:
☐**MD** ☐**DO** ☐ **NP** ☐**PA**

________________________ ________________________
Print Provider Name* **Provider Signature***

________________________ ________________________
Provider NPI Number* **Date***

________________________ **(   )   -**________
Clinic or Vendor Name **Phone**