Follow up Appointment Review

Name_____ DOB _____ Date_____

Who is your Primary Care Physician? _____Reason for Visit Today_____

Pharmacy Name, Location, and Phone Number_____

Since your last visit with us have you experienced any…			**Describe changes below:**
Medication changes	☐ YES	☐ NO	_____
New drug or latex allergies	☐ YES	☐ NO	_____
Lab work	☐ YES	☐ NO	When_____
Hospitalization or ER visit	☐ YES	☐ NO	When_____ Where_____
Surgical procedures	☐ YES	☐ NO	Type_____ Where_____
New illnesses	☐ YES	☐ NO	_____
Family history illness changes	☐ YES	☐ NO	_____
Do you use oxygen?	☐ YES	☐ NO	If yes, how often ☐ As Needed ☐ Continuous ☐ At Bedtime
Do you use CPAP?	☐ YES	☐ NO	If yes, how often ☐ Occasionally ☐ Every Night ☐ With Naps

Smoking Status:

☐ Current Every Day Smoker
☐ Current Some Day Smoker
☐ Former Smoker
☐ Never Smoker
☐ Heavy Cigar/Pipe Smoker
☐ Light Cigar/Pipe Smoker

Type of Tobacco:

☐ Cigarettes
☐ Cigars
☐ Pipe
☐ Chewing Tobacco
☐ Vapor/E-Cigarettes
☐ Snuff
☐ Smokeless Tobacco/Other

Review of Systems:

Please check any of the symptoms you are currently experiencing. Any unchecked boxes will be assumed to be negative. Please check here if you are not experiencing any of the below symptoms: ☐

Constitutional
_____ Fatigue
_____ Fever
_____ Insomnia
_____ Weight gain
_____ Weight loss

Head/Neck
_____ Headache
_____ Neck Pain

Eyes
_____ Blurred vision
_____ Decreased vision
_____ Glaucoma
_____ Cataracts

Ear, Nose, Mouth, and Throat
_____ Earache
_____ Nasal Congestion
_____ Sore throat
_____ Ringing in ears

Cardiovascular
_____ Chest pain
_____ Pain in legs with walking
_____ Decreased exercise tolerance
_____ Palpitation
_____ Awakened with breathing difficulty
_____ Difficulty breathing lying flat
_____ Swelling in your legs/feet

Pulmonary
_____ Cough
_____ Shortness of breath
_____ Snoring
_____ Sputum production
_____ Wheezing

Gastrointestinal
_____ Abdominal pain
_____ Constipation
_____ Diarrhea
_____ Heartburn
_____ Blood in stools
_____ Loss of appetite
_____ Nausea
_____ Vomiting

Genitourinary
_____ Pain on urination
_____ Urinary frequency
_____ Incontinence
_____ Frequent urination at night
_____ Urinary hesitancy

Musculoskeletal
_____ Back pain
_____ Foot pain
_____ Joint pain/stiffness
_____ Hip pain

Neurologic
_____ Confusion
_____ Lightheaded
_____ Loss of balance/coordination
_____ Slurred speech
_____ Passing out
_____ Weakness

Psychiatric
_____ Anxiety
_____ Depression

Peripheral Vascular Disease

Do you experience aching or cramping in your legs, thighs, or buttocks when walking or exercising? ☐ YES ☐ NO
If yes, does the pain go away with rest? ☐ YES ☐ NO
Do you have open sores or ulcers on your leg(s) or feet that will not heal? ☐ YES ☐ NO
Do you suffer from varicose veins/spider veins? ☐ None ☐ Some ☐ Moderate ☐ Severe
Do you wear compression stockings? ☐ None ☐ Intermittent ☐ Daily

Comments _____

Form Revision #	Form Changes
OHHP-F584 (Rev. 1/18)	Changed Logo
OHHP-F584 (Rev.11/20)	Removed Logo

Patient Name:_____

Admission Date:_____DOB:_____

MSP Questionnaire

PART I

1. Are you currently enrolled in a SNF or Hospice facility?

   ☐ Yes. What is the name, address and phone number of the facility?
   Name: _____Address:_____Phone:_____
   _____

   ☐ No.

2. Are you receiving Black Lung (BL) Benefits?

   ☐ Yes. Date benefits began: ____/____/____ MM/DD/YY
   (Staff only: BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.)
   ☐ No.

3. Are the services to be paid by a government research program?

   ☐ Yes. **(Staff only: GOVERNMENT PROGRAMS WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.)**
   ☐ No.

4. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

   ☐ Yes**. (Staff only: DVA IS PRIMARY FOR THESE SERVICES.)**
   ☐ No.

5. Was the illness/injury due to a work-related accident/condition?

   ☐ Yes. Date of injury/illness: ____/____/____ MM/DD/YY
   Patient: IF YES, GO TO PART III AND CONTINUE.
   (Staff only: WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS.)
   ☐ No.

PART II

1. Was the illness/injury related to a non-work related accident?

   ☐ Yes. Date of injury/illness: ____/____/____ MM/DD/YY
   ☐ No. P**atient: IF NO, GO TO PART III.**

2. Is no-fault insurance available?

   ☐ Yes. **Patient: IF YES, GO TO PART III AND CONTINUE.**
   (Staff only: WE DO NOT FILE NO-FAULT INSURANCE. PATIENT WILL BE SELF PAY.)
   ☐ No.

3. Is liability insurance available?

   ☐ Yes. **(Staff only: WE DO NOT FILE LIABILITY INSURANCE. PATIENT WILL BE SELF PAY.)**
   ☐ No.

Patient Name:_____

PART III

1. Are you entitled to Medicare based on:

   ☐ Age **Patient: COMPLETE PART IV ONLY.**
   ☐ Disability **Patient: COMPLETE PART V ONLY.**
   ☐ End-Stage Renal Disease (ESRD) **Patient: COMPLETE PART VI ONLY.**

PART IV - Age

1. Are you currently employed?

   ☐ Yes. ☐ No. ☐ No, never employed. ☐ No, retired. Date of retirement: ____/____/____ MM/DD/YY

2. Is your spouse currently employed?

   ☐ Yes. ☐ No. ☐ No, never employed. ☐ No, retired. Date of retirement: ____/____/____ MM/DD/YY

   Patient: IF NO TO BOTH QUESTIONS 1 AND 2, STOP. DO NOT PROCEED. **(Staff: MEDICARE IS PRIMARY.)**
   Patient: IF YES TO QUESTIONS 1 AND 2, CONTINUE.

3. Do you have a Group Health Plan (GHP) coverage based on your own or your spouse's current/former employment?

   ☐ Yes, both. ☐ Yes, self. ☐ Yes, spouse.

   ☐ No.

4. Are you covered under the Group Health Plan (GHP) of a family member other than your spouse?

   ☐ Yes.
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS 1 OR 2.)**

5. Does the employer that sponsors the patient's Group Health Plan (GHP) employ 20 or more employees?

   ☐ Yes. **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS 1 OR 2.)**

6. Does the employer that sponsors your Group Health Plan (GHP) employ 100 or more employees?

   ☐ Yes. **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS 1 OR 2.)**

Patient Name:_____

PART V - Disability

1. Are you currently employed?

   ☐ Yes. ☐ No. ☐ No, never employed. ☐ No, retired. Date of retirement: ____/____/____ MM/DD/YY

2. Do you have a spouse who is currently employed?

   ☐ Yes. ☐ No. ☐ No, never employed. ☐ No, retired. Date of retirement: ____/____/____ MM/DD/YY

   Patient: IF NO TO BOTH QUESTIONS 1 AND 2, STOP. DO NOT PROCEED. **(Staff: MEDICARE IS PRIMARY.)**
   Patient: IF YES TO QUESTIONS 1 AND 2, CONTINUE.

3. Do you have a Group Health Plan (GHP) coverage based on your own or your spouse's current/former employment?

   ☐ Yes, both. ☐ Yes, self. ☐ Yes, spouse.

   ☐ No.

4. Are you covered under the Group Health Plan (GHP) of a family member other than your spouse?

   ☐ Yes.
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS IN PART I OR II.)**

5. Does the employer that sponsors the patient's Group Health Plan (GHP) employ 20 or more employees?

   ☐ Yes. **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS IN PART I OR II.)**

6. Does the employer that sponsors your Group Health Plan (GHP) employ 100 or more employees?

   ☐ Yes. **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.)**

PART VI – End-Stage Renal Disease (ESRD)

1. Do you have a Group Health Plan (GHP) coverage based on your own or your spouse's current/former employment?

   ☐ Yes.
   ☐ No.

2. Are you covered under the Group Health Plan (GHP) of a family member other than your spouse?

   ☐ Yes.
   ☐ No. **(Staff: MEDICARE IS PRIMARY.)**

Patient Name:_____

PART VI – End-Stage Renal Disease (ESRD) Continued

3. Does the employer that sponsors the patient's Group Health Plan (GHP) employ 20 or more employees?

   ☐ Yes. **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS IN PART I OR II.)**

4. Does the employer that sponsors your Group Health Plan (GHP) employ 100 or more employees?

   ☐ Yes. **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.)**

5. Have you ever received a kidney transplant?

   ☐ Yes. Date of transplant: ____/____/____ MM/DD/YY
   ☐ No.

6. Have you received maintenance dialysis treatments?

   ☐ Yes. Date of maintenance: ____/____/____ MM/DD/YY
   ☐ No.

7. Are you within the 30-month coordination period?

   ☐ Yes. Date coordination period began: ____/____/____ MM/DD/YY
   ☐ No. **Patient: STOP. DO NOT PROCEED.** **(Staff: MEDICARE IS PRIMARY.)**

8. Are you entitled to Medicare on the basis of either (ESRD and AGE) or (ESRD and DISABILITY)?

   ☐ Yes.
   ☐ No. **(Staff: GHP IS PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.)**

9. Was the initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?

   ☐ Yes. **(Staff: GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.)**
   ☐ No. **(Staff: INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.)**

10. Does the working age or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?

    ☐ Yes. **(Staff: GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.)**
    ☐ No. **(Staff: MEDICARE CONTINUES TO PAY PRIMARY.)**

Date & Version #	Form Changes
OHHP-F496 (Rev. 1/18)	Changed Logo
OHHP-F496 (Rev. 11/20)	Removed Logo