HEDIS Fax Back Form MY2023

This form allows providers to submit evidence of services provided where a claim cannot be generated for a service. This information is used in calculating HEDIS-based performance rates for participating MDwise providers. **This form must be accompanied by medical record documentation of the stated information.**

IF A CLAIM SHOULD BE SUBMITTED FOR THIS SERVICE; SUBMIT A CLAIM RATHER THAN THIS FORM.

Provider Name: _____ Provider NPI: _____

Office Contact: _____ Phone: _____ Email: _____

Member Name: _____ MID: _____ DOB:_____

Instructions:

1. Indicate one or more of the following by checking the corresponding checkbox. You may and should submit all measures under a section for a patient. For example, for a diabetic patient, submit information for all diabetic measures and blood pressure measurements.

2. Documentation of services provided must include:
   - Date of visit
   - Member name
   - Date of Birth
   - Provider name who performed the services

3. If a claim was submitted to another payer for this service (but not to MDwise), submit a copy of the superbill for that service (rather than medical record documentation).

4. If a claim cannot be generated and there is no superbill for the service, submit medical record documentation demonstrating that the required components were provided.

5. **Send all required information, along with this filled out form, to faxback@mdwise.org**

☐ **DIABETES Measures – use the date that corresponds to the documentation you are sending (HBD, EED, BPD, KED).**

Date of Diabetes (Type 1 or 2) Diagnosis: _____ Diagnosis Code (ICD-10): _____

Latest 2023 Hemoglobin A1c Measurement Date: _____ Hemoglobin A1c Value: _____

Latest 2023 or 2022 Date of Retinal Eye Exam: _____ Result of Retinal Eye Exam: _____

Date of Kidney Health Evaluation: _____ Result of the Kidney Health Evaluation: _____

2023 Date of Kidney Health Evaluation: Glomerular Filtration Rate Test (eDGF): _____ Date: _____

2023 Date of Kidney Health Evaluation: Urine Albumin-Creatinine Ratio Test**:** _____ Date: _____

2023 Blood Pressure Measurement Date(s) and Blood Pressure Reading(s) taken in the office - (List all dates that blood pressure was taken; dates must correspond to the documentation you are sending). **Please send copies of office notes or vital signs flowsheets/charts. We cannot count blood pressure reading taken in the emergency department or inpatient.**

Date of Blood Pressure Reading	Systolic Reading	Diastolic Reading

☐ **PRENATAL AND POSTPARTUM Measures (PPC)**

☐ *If the member did not experience a live birth between October 8, 2022, and October 7, 2023, please check this box.*

Actual delivery date for the live birth between 10/8/2022 and 10/7/2023: _____

Send copies of office notes for all prenatal visits for the above delivery date for which documentation is being submitted. Please include copies of the prenatal flowsheets with your documentation.

Date of office notes for postpartum visit(s) between 7 and 84 days after delivery for which documentation is being submitted:

_____

Date of prenatal depression screening for which documentation is being submitted (PND-E): _____

Date of postpartum depression screening for which documentation is being submitted (PDS-E): _____

For prenatal/postpartum depression screenings send documentation for all the below pertaining to the above noted delivery date:

- ☐ Copies of all prenatal and postpartum depression screenings with results.
- ☐ Any outpatient visits during the prenatal/postpartum period with a diagnosis of depression or other behavioral health diagnosis and/or a dispensed antidepressant medication.

☐ **CHILD AND YOUTH Measures**

For children who turned ages 3-17 in 2023:

Date of 2023 well-child visit for which documentation is being submitted (WCV): _____

For children who turned 13 years of age in 2023 **(Must send copies of all immunization records)**:

Date(s) of immunization for which documentation is being submitted (IMA): _____
Add additional dates, if needed.
Immunizations received on this date:

- ☐ Meningococcal Serogroups A, C, W, Y
- ☐ Tdap
- ☐ HPV

For children who were 0-15 months in 2023:

Date(s) of 0–15-month well-child visit(s) for which documentation is being submitted (W30):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

For children who turned 2 years of age in 2023 **(Must send documentation of the lead screening test with results and copies of all immunization records)**:

Date of lead screening by age 2 for which documentation is being submitted (LSC): _____

Date(s) of immunization for which documentation is being submitted (CIS): _____

Add additional dates, if needed.

Immunizations received on this date:

☐ DTaP	☐ HiB	☐ Pneumococcal Conjugate	
☐ IPV	☐ Hepatitis B	☐ Hepatitis A	
☐ MMR	☐ VZV	☐ Rotavirus	☐ Influenza

Notes: _____