Annual Care for Older Adults (COA) Form

Read Carefully

This form must be reviewed with the member and signed by a prescribing practitioner or clinical pharmacist. This form must be completed and uploaded in the patient's clinical medical record.

Please fax the completed form to 833-813-0039. This form is available at www.healthnet.com> *Providers> Provider Quality Improvement> HEDIS Measures & Billing Codes* or go directly to https://bit.ly/HEDISMeasuresandBillingCodes.

Patient Name: _____ DOB: _____ /_____ /_____ ID #: _____

Medication List and Review (CPT II: 1159F and 1160F)
Attach the member's medication list OR document all prescriptions, over-the-counter and herbal supplements below.

This section must be reviewed and signed by a prescribing provider or clinical pharmacist. Please include a medication list (documented below or attach current medication list).

Date Reviewed: _____ /_____ /_____ ☐ Medication List attached.

☐ Patient not taking any medications.

Medication/Dosage/Frequency	Medication/Dosage/Frequency

Provider Name (Print):_____

Credentials: ☐ MD ☐ DO ☐ NP ☐ PA ☐ PharmD ☐ Other: _____

Provider Signature: _____Date: _____ /_____ /_____

☐ I confirm that this document is also filed in the member's legal health/outpatient record.

If the form is filled out by an office or clinical support staff member, it must route back to the provider for follow-up and sign off.

25-263 (3/25)