Prospective Fax Coversheet for Measurement Year 2022

19298

Johns Hopkins HealthCare LLC
Quality Improvement Department
7231 Parkway Drive
Hanover, MD 21076
Fax: 410-424-4882

*** Todays Date**

PLEASE READ CAREFULLY

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Instruction for completing this form:

- Please Print Clearly - All lines with * must be completed.
- Please use this format for all Dates: 00/00/0000
- Please send medical records for the following health plans: • Priority Partners • EHP • USFHP • JH Advantage MD
- **Member Name and Date of Birth** must be on ALL medical record pages. Member's age is not considered date of birth.
- For information on what to send as supplemental data please refer to the online Quality Measure Toolkit
- Once information is received and processed, please allow approximately 4-6 weeks before the member will be removed from your Opportunity Report or the Gaps in Care Report.
- Return this form with the complete signed Medical Record information via Fax: 410-424-4882 with a fax cover sheet. One member per form only. **Data submission deadlines: Dates of Service 1/1-10/31/2022 must be received by 12/16/2022. Dates of Service 11/1-12/31/2022 must be received by 1/13/2023.**

* Indicate the Health Screenings Services by marking the appropriate BOX:

	Adolescent Immunizations (IMA) HPV: Meningococcal Conjugate (Menvo) :T-Dap		**Breast Cancer Screening (BCS)**
	Cervical Cancer Screening (CCS) (Pap Smear or Total Hyst. cervix absent)		**Childhood Immunizations Status (CIS)**
	Colorectal Screening (COL)		**Controlling Blood Pressure (CBP)** Last BP of the year
	HbA1c Control for Patients With Diabetes (HBD) CPT II Claim Coding preferred		**BP Control for** Patients **With Diabetes (BPD)** Last BP of the year
	Eye Exam for Patients With Diabetes (EED) (date done and retina status)		**Prenatal/Postpartum (PPC)** CPT II Claim Coding preferred
	Transitions of Care (TRC) (Medicare ONLY)		**Weight Assessment and Counseling in Children (WCC)**

*** Please Print Members Name: (Last Name First Name)**

*** Date of Birth**

*** Provider's Office Name (EMR Access Y or N)**

*** Date of Service**

*** Office Contact Person**

*** Phone Number**

*** Fax Number**