Well-Care Visits

Please fax completed forms and medical record documentation to **833-667-1532** or send to our secure email **MIHEDIS@mhplan.com** and save a copy in the patient's medical record.

Patient Name: ___________________________ DOB: ________ID#:____________________________

Date Vitals Collected: ___/___/____ Height: ___ft.___ in. Weight: ______lbs. BMI Percentile: ______

BMI Percentile should be assessed for all patients 17 years and younger.

<table>
<tr><td colspan="2">Well-Child Visit completed by Primary Care Provider (PCP): Complete at least six visits for patients ages <u>0-15 months</u>.
Date Completed:_____/_____/_____ Date Completed:_____/_____/_____
Date Completed:_____/_____/_____ Date Completed:_____/_____/_____
Date Completed:_____/_____/_____ Date Completed:_____/_____/_____</td></tr>
<tr><td>Well-Child Visit completed by PCP: Complete at least two visits for patients ages <u>15-30 months.</u>
Date Completed:_____/_____/_____
Date Completed:_____/_____/____</td><td>Well-Child Visit or Sports/School Physical completed by PCP or OB-GYN: Complete at least one visit annually for patients ages <u>3-21 years.</u> Date Completed:_____/_____/_____</td></tr>
<tr><td>Counseling for Nutrition:
Date Completed:_____/_____/_____ Select all that apply:
☐ Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)
☐ Checklist indicating nutrition was addressed
☐ Counseling or referral for nutrition education
☐ Member received educational materials on nutrition during a face-to-face visit ☐ Anticipatory guidance for nutrition
☐ Weight or obesity counseling</td><td>Counseling for Physical Activity: Date Completed:_____/_____/_____ Select all that apply:
☐ Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation)
☐ Checklist indicating physical activity was addressed
☐ Counseling or referral for physical activity
☐ Member received educational materials on physical activity during a face-to-face visit
☐ Anticipatory guidance specific to the child's physical activity
☐ Weight or obesity counseling</td></tr>
</table>

*Please do not fill out unless well-child visit has been marked above.

Provider Name and Credentials (Print): ____

Provider Signature: _______________________________________ Date: _____/______/_____

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 signoff.