

wellcare								
Agenda ID:								
, Member DOB: / / TIN Name:					Member Phone:			
Provider Name and ID:					IPAA Name:			
					pointment Agenda patient's visit			
Please update diag	are based on cla gnoses, as these	aims submit e conditions	tted by prov s may no lor	nger exist, their s	ember's medical history as everity may have changed c submission, please use	, or other condit		replaced them.
Suspected Rx/Condition Type Se			Source	ource Diagnosis			Active Diagnosis & Documented	Resolved or Not Present
Persistency = DX Code(s) have appeared in prior claims. Predictive = Possible condition(s) based on prior claims.								
Care Guidance Address and docu For additional info				,	a claim, CPT, CPTII, HCPC	S, DX codes or a	pplicable docu	mentation.
Measure			Servic Start	ee Window Date	Service Window End Date	Compliant Indicator		
For questions	on the Appoir	ntment Ag	enda form	, please contac	t your Provider Repres	entative.		
Please comple	ete form, sign,	and send	via fax to	1-813-464-8879	or via secure email, a	genda@wellca	re.com.	
All current Diag	gnoses and Ca	re Gaps for	2024 date	s of service mus	st be documented in the	patient's chart	and submitte	d on claims.
E	Provider Signature:					Date:/		
	Provider Printed Name:					Provider Credentials: MD DO PA NP (Circle one.)		



https://www.centene.com/ content/dam/corporate/ educational-resources/2024-CoC-Program-FAQ.pdf

Through submission of this form, providers attest that the information indicated on this agenda and subsequent claim submissions are accurate based on your assessment during the encounter with member and are appropriately documented in the medical record.