

ADVANCE CARE PLANNING (ACP) – PHYSICIAN ATTESTATION

Instructions: Complete sections I through VI, date, sign, and submit to:
Partnership HealthPlan of California
Attn: Cindi Ardans, QM/I Manager
360 Campus Lane, Suite 100
Fairfield, CA 94534

I. Patient Name:	II. DOB:
III. PHC member/CIN #:	IV. Date(s) of service:
V. Major disease process (circle all appropriate) a. Cancer (Metastatic/Recurrent) b. Advanced COPD c. Stroke (w/at least 50% decreased function) d. End stage renal disease e. Advanced cardiac disease (end-stage CHF, severe CAD, CM [LVEF <25%]) f. Other potential life-limiting illness or concomitant disease process; specify _____	

VI. Attestation of ACP Services

I hereby attest that I completed the following activities on the date(s) indicated above for the patient listed:

- Advance Directive (AD) discussed – patient completed AD
- Advance Directive (AD) discussed – patient refused to complete AD at this time
- Care plan discussed and developed with patient and/or family members/caretakers
- Patient educated re: POLST form, form completed, encouraged patient/caretaker to share with family and other treating practitioners
- Patient educated re: POLST form, patient elected not to complete form at this time

I am submitting this invoice to bill Partnership HealthPlan of California \$100 for Advance Care Planning services rendered to the above indicated patient on the date(s) listed.

Physician Name (print):
Physician Signature:
Date Completed:
Name of payee (print):
Tax ID of payee: