History & Physical (H&P) Form
Mi Via, NM Self-Directed Medicaid Waiver Program

(If your office or practice has its own H&P form, it may be used in place of this form. Please see delivery instructions bottom Page 2.)

Today's Date:_____

Patient Name: _____ Date of Birth: _____

Vital Signs

Pulse: Resp: Temp: BP:

Ht: Wt:

Diagnosis(es) and ICD-9 code:

Current Medications (including OTC and supplements, if known):

Brief medical history, with specific attention to reasons for any disability (may be physical and/or cognitive/behavioral):

General/Constitutional:

Skin/Breast:

Eyes/Ears/Nose/Mouth/Throat:

Continued, Mi Via, History & Physical /Participant Name: _____

Cardiovascular:

Respiratory:

Gastrointestinal:

Genitourinary:

Musculoskeletal:

Neurologic/Psychiatric:

Allergic/Immunologic/Lymphatic/Endocrine:

Follow up/Comments:

Provider (MD, DO, CNP or PAC <u>only</u>) Signature and Title:

_____ Date: _____

Office Telephone: _____

Please mail or Fax to:
Molina-Third Party Assessor
P.O. Box 3909
Albuquerque, NM 87190
Fax: (866) 553-9268, (866) 553-9272 <u>or</u>
(866) 553-9359

For Hand Delivery:
Molina-Third Party Assessor
8801 Horizon Blvd. NE
Albuquerque, NM 87113-1533