Comagine Health

New Mexico Medicaid Checklist
Mi Via Developmental Disabilities Level of Care

Participant or consultant to provide the following fully completed documents with required signatures:

- ☐ MAD 378
- ☐ History and Physical (H&P)
  Disclaimer: The H&P form attached is an example of what is needed for this requirement, but the H&P can follow any format issued by the physician office.

Please double check the accuracy of all information submitted:

- ☐ Correct spelling of recipient name
- ☐ Accuracy of recipient Medicaid ID
- ☐ Recipient date of birth
- ☐ Completed assessment factor scores
- ☐ Signature of physician or person completing form on MAD 378

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:

SAMPLE

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

Cardiovascular:

Respiratory:

Gastrointestinal:

Genitourinary:

Musculoskeletal:

Neurologic/Psychiatric:

Allergic/Immunologic/Lymphatic/Endocrine:

Follow up/Comments:

SAMPLE

Provider (MD, DO, CNP or PAC only) Signature and Title:

_____ Date: _____

Office Telephone: _____

Please mail or Fax to:
Comagine Health - Third Party Assessor
PO Box 20910
Albuquerque, NM 87154-0910

Mi Via Waiver Fax Line: (800) 251-9993 (Toll Free)