SOLIS
HEALTH PLANS

HEDIS MY2025 Screening Test Form

Dear Valued Provider:

Solis Health Plans is deeply committed to supporting our members and advancing quality initiatives aimed at improving health outcomes. As part of our ongoing efforts, we are pleased to share the **HEDIS MY2025 Screening Test form**.

This form has been developed to streamline supplemental data collection and may be used as an alternative method for closing gaps in care. Please note the following:

- Patient self-reported information is considered acceptable for compliance.
- Once completed and signed by the ongoing primary care provider, submit to us via **email** or **fax**.

Providers can **submit any type of Supplemental Data** to Solis Health Plans in several ways:

- **Email :** hedisfax@solishealthplans.com
- **Fax :** 305-675.5972

We kindly ask that you share this form with your providers and staff.

Your continued collaboration is essential to ensuring accurate reporting and achieving the highest standards of care for our members.

Should you have any questions or require additional assistance, please do not hesitate to contact us.

SOLIS HEALTH PLANS

SCREENING TESTS FORM
HEDIS (Project)

Member Name: _____ **DOB:** ____ / ____ / _____ **ID:** _____

Please fill out the information and return it back. ***A report is not required.***
Patient self-reported information is considered acceptable to meet compliance requirements.

1. **Breast Cancer Screening (BCS)** Completed: Month and Year of service: _____ (MM/YYYY)

2. **Colorectal Cancer Screening (COL)** Completed. Check at least ONE when applicable.
   - ***Fecal occult blood test (FOBT)*** *or* ***Fecal Immunochemical Test (FIT)*** *during the current measurement year (2025):* ☐ *Yes* ☐ *No*
   - ***Cologuard (fecal immunochemical test [FIT]-DNA)*** *between (2023-2025): Year Of Service* _____
   - ***CT colonography*** *between 2022-2025: Year Of Service* _____
   - ***Flexible sigmoidoscopy or CT colonography*** *between 2021-2025: Year Of Service* _____
   - ***Colonoscopy*** *between 2016-2025: Year Of Service* _____

3. **Retinal Eye Exam for Patients with Diabetes (EED)** between 2024 and 2025
   - Documentation in the medical record with that a Retinal eye exam with interpretation by an eye care provider documented and reviewed **without** evidence of retinopathy: *Year Of Service* _____
   - Documentation in the medical record with that a Retinal eye exam with interpretation by an eye care provider documented and reviewed **with** evidence of retinopathy: *Year Of Service* _____

4. **Controlling Blood Pressure (CBP)** *(must be <140mm Hg/90mm Hg to be numerator compliant)*
   SBP _____ DBP: _____ Date of Service: _____

5. **Hemoglobin A1c:** (must be **≤ 9.0% to be numerator compliant).** Completed
   HbA1c: _____ Date of Service: _____

6. **Kidney Health Evaluation (KED):** Completed
   - eGFR Date of Service: _____
   - Albumin/Creatinine ratio Date of Service: _____

7. **Bone Mineral Density (DEXA) Scan:** Completed
   - Month and Year of service: _____

Primary Care Provider's Signature: _____ **Clinic Name** _____**Date:** _____
(digital signature is acceptable)

Solis Health Plans - 9250 NW 36th Street, Ste. 400 - Doral, FL 33178
Once signed and completed please send it via email at hedisfax@solishealthplans.com, OR, via fax at 305.675.5972