




Your Guide to Medicare Preventive Services

CENTERS FOR MEDICARE & MEDICAID SERVICES

This is the official government booklet with important information about:

- What disease prevention is and why it's important
- Which preventive services Medicare covers and how often
- Who can get services
- What you pay – you pay nothing for many services

YOUR GUIDE TO MEDICARE PREVENTIVE SERVICES



Now's the time to get the most out of your Medicare. The best way to stay healthy is to live a healthy lifestyle. You can live a healthy lifestyle and prevent disease by exercising, eating well, keeping a healthy weight, and not smoking.

Medicare can help. Medicare pays for many preventive services to keep you healthy. Preventive services can find health problems early, when treatment works best, and can keep you from getting certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

If you have Medicare Part B (Medical Insurance), you can get a yearly “Wellness” visit and many other covered preventive services.

Whether it's online, in person, or on the phone, Medicare is committed to helping people get the information they need to make smart choices about their Medicare benefits.

MyMedicare.gov

Register at MyMedicare.gov to get direct access to your preventive health information—24 hours a day, every day. You can track your preventive services, get a 2-year calendar of the Medicare-covered tests and screenings you're eligible for, and print a personalized “on-the-go” report to take to your next doctor's appointment.

How can this booklet help me?

This booklet covers Part B-covered preventive services. The alphabetical list on the following pages gives information about what you pay if you have Original Medicare and see doctors or other health care providers who accept assignment. You'll pay more if you see doctors or providers who don't accept assignment. If you're in a Medicare health plan or have other insurance, your costs may be different. Contact your plan or benefits administrator directly to find out about the costs.

“Your Guide to Medicare's Preventive Services” isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

SECTION

Introduction

Talk to your doctor or health care provider

Talk to your doctor or health care provider to find out which preventive services are right for you and how often you need them. Your doctor or health care provider may do exams or tests that Medicare doesn't cover. Your doctor or health care provider also may recommend that you have tests more or less often than Medicare covers them. Medicare pays for some diagnostic tests. Your doctor or other health care provider may recommend a diagnostic test when a screening test or exam shows an abnormality. In some cases, you may have to pay for these services.

If a service you get isn't covered and you think it should be, you may appeal this decision. To file an appeal, follow the instructions on your "Medicare Summary Notice" (MSN). The MSN is an easy-to-read statement that clearly lists your health insurance claims information. For more information on filing an appeal, visit [Medicare.gov/appeals](https://www.medicare.gov/appeals), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Things to know when reading this booklet**Symbols**

You'll see one of these symbols next to each preventive service. It tells you for whom Medicare covers the service or test.

Remember—The services listed in this booklet are covered if you have Medicare Part B (Medical Insurance).



Men only



Women only



Men & women

Things to know when reading this booklet (continued)

Risk factors

You'll see lists of factors that increase your risk of developing a certain disease. If you're not sure if you're at high risk, talk to your doctor.

Part B deductible

The Part B (Medical Insurance) deductible in 2019 is \$185. This amount may change yearly.

Medicare-approved amount

In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Assignment

Assignment is an agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Drug coverage

Medicare Part D covers prescription drugs that may help you treat a disease or condition found by preventive screening tests, like high cholesterol. You can review and compare cost and coverage information of Medicare drug plans by visiting [Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan). Generally, you can join a Medicare drug plan between October 15–December 7. Your coverage will begin on January 1 of the following year. You can get personalized help by visiting [Medicare.gov](https://www.medicare.gov), or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

SECTION

Preventive Services

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The alphabetical list on the following pages gives information about Medicare preventive services.



Abdominal aortic aneurysm screening

Who's covered?

Medicare covers a one-time abdominal aortic aneurysm ultrasound for people at risk. You're considered at risk if you have a family history of abdominal aortic aneurysms, or you're a man 65–75 and have smoked at least 100 cigarettes in your lifetime.

How often is it covered?

Medicare covers this screening once in your lifetime if you get a referral from your doctor.

Your costs if you have Original Medicare

You pay nothing for this screening if the doctor or other qualified health care provider accepts assignment.

Remember—The services listed in this booklet are covered if you have Medicare Part B (Medical Insurance).



Alcohol misuse screening and counseling

Who's covered?

Adults with Medicare (including pregnant women) who use alcohol, but don't meet the medical criteria for alcohol dependency.

How often is it covered?

Medicare covers one alcohol misuse screening per year. If your primary care doctor or other primary care practitioner determines you're misusing alcohol, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling). The practitioner must provide the counseling in a primary care setting (like a doctor's office).

Your costs if you have Original Medicare

You pay nothing if the doctor accepts assignment.



Bone mass measurements

Medicare covers bone mass measurements to see if you're at risk for broken bones due to osteoporosis. Osteoporosis is a disease in which your bones become weak and brittle. In general, the lower your bone density, the higher your risk for a fracture. Bone mass measurement results will help you and your doctor choose the best way to keep your bones strong.

Who's covered?

Bone mass measurements are covered for certain people with Medicare whose doctors say they're at risk for osteoporosis, and who have one of these medical conditions:

- A woman whose doctor or health care provider says she's estrogen-deficient and at risk for osteoporosis, based on her medical history and other findings
- A person with vertebral abnormalities as demonstrated by an X-ray
- A person getting (or expecting to get) steroid treatments
- A person with hyperparathyroidism
- A person taking an osteoporosis drug

How often is it covered?

Once every 24 months (more often if medically necessary).

Your costs if you have Original Medicare

You pay nothing for this test if the doctor accepts assignment.



Breast cancer screening (mammograms)

Breast cancer is the most common non-skin cancer in women and the second leading cause of cancer death in women in the U. S. Every woman is at risk, and this risk increases with age. Breast cancer usually can be treated successfully when found early. Medicare covers screening mammograms to check for breast cancer before you or a doctor may be able to find it manually.

Who's covered?

Women 40 and older are eligible for a screening mammogram every 12 months. Medicare also covers one baseline mammogram for women between 35–39.

How often is it covered?

Once every 12 months.

Your costs if you have Original Medicare

You pay nothing for the test if the doctor accepts assignment.

Am I at risk for breast cancer?

Your risk of developing breast cancer increases if any of these are true:

- You had breast cancer in the past.
- You have a family history of breast cancer (like a mother, sister, daughter, or 2 or more close relatives who've had breast cancer).
- You had your first baby after 30.
- You've never had a baby.



Cardiovascular disease (behavioral therapy)

Who's covered?

All people with Medicare.

What's covered?

A cardiovascular disease risk reduction visit that includes:

- Encouraging aspirin use when benefits outweigh risks
- Screening for high blood pressure
- Counseling to promote a healthy diet

Cardiovascular disease (behavioral therapy) (continued)

How often is it covered?

Once each year.

Your costs if you have Original Medicare

You pay nothing if your doctor accepts assignment.



Cardiovascular disease screening

Medicare covers cardiovascular disease screenings that check your cholesterol and other blood fat (lipid) levels. High levels of cholesterol can increase your risk for heart disease and stroke. These screenings will tell if you have high cholesterol.

Who's covered?

All people with Medicare when a doctor orders the screening.

What's covered?

Tests for cholesterol, lipid, and triglyceride levels.

How often is it covered?

Once every 5 years.

Your costs if you have Original Medicare

You pay nothing for this screening.



Cervical and vaginal cancer screening

Medicare covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the pelvic exam, Medicare also covers a clinical breast exam to check for breast cancer.

Who's covered?

All women with Medicare.

How often is it covered?

Medicare covers these screening tests once every 24 months, or once every 12 months if you're at high risk for cervical or vaginal cancer, or if you're of child-bearing age and had an abnormal Pap test in the past 36 months.

Part B also covers Human Papillomavirus (HPV) tests (as part of Pap tests) once every 5 years if you're 30-65 without HPV symptoms.

Cervical and vaginal cancer screening (continued)

Your costs if you have Original Medicare

You pay nothing for the lab Pap test and for the lab HPV with Pap test. You also pay nothing for the Pap test specimen collection and pelvic and breast exams if the doctor accepts assignment.

Am I at high risk for cervical cancer?

Your risk for cervical cancer increases if any of these are true:

- You've had an abnormal Pap test.
- You've had cervical or vaginal cancer in the past.
- You have a history of sexually transmitted disease (including HIV infection).
- You began having sex before 16.
- You've had 5 or more sexual partners.
- Your mother took DES (Diethylstilbestrol), a hormonal drug, when she was pregnant with you.



Colorectal cancer screening

Medicare covers colorectal cancer screening tests to help find pre-cancerous polyps (growths in the colon), so polyps can be removed before they become cancerous and to help find colorectal cancer at an early stage when treatment works best.

Who's covered?

All people with Medicare 50 and older, but there's no minimum age for having a covered screening colonoscopy.

How often is it covered?

- **Screening fecal occult blood test**—Once every 12 months for people 50 or older.
- **Screening flexible sigmoidoscopy**—Once every 48 months after the last flexible sigmoidoscopy or barium enema, or 120 months after a previous screening colonoscopy.
- **Screening colonoscopy**—Once every 120 months (high risk every 24 months), or 48 months after a previous flexible sigmoidoscopy.
- **Screening barium enema**—Once every 48 months (high risk every 24 months) when used instead of sigmoidoscopy or colonoscopy.

Colorectal cancer screening (continued)

How often is it covered?

- **Multi-target stool DNA test**—Once every 3 years if you meet all of these conditions:
 - You're between 50–85.
 - You show no signs or symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test, or fecal immunochemical test.
 - You're at average risk for developing colorectal cancer, meaning you have no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.
 - You have no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.

Your costs if you have Original Medicare

You pay nothing for the fecal occult blood test, if you get a written referral from your doctor, physician assistant, nurse practitioner, or clinical nurse specialist. You pay nothing for the flexible sigmoidoscopy or screening colonoscopy if your doctor accepts assignment.

Note: If a polyp or other tissue is found and removed during the colonoscopy, you may have to pay 20% of the Medicare-approved amount for the doctor's services and a copayment in a hospital outpatient setting.

For barium enemas, you pay 20% of the Medicare-approved amount for the doctor's services. The Part B deductible doesn't apply. If it's done in a hospital outpatient setting, you pay a copayment.

Am I at high risk for colorectal cancer?

Risk for colorectal cancer increases with age. It's important to continue with screenings, even if you were screened before you had Medicare. Your risk for colorectal cancer increases if any of these are true:

- You've had colorectal cancer before.
- You have a close relative who had colorectal polyps or colorectal cancer.
- You have a history of polyps.
- You have inflammatory bowel disease (like ulcerative colitis or Crohn's disease).



Depression screening

Who's covered?

All people with Medicare.

How often is it covered?

Medicare covers one depression screening per year. The screening has to be done in a primary care setting (like a doctor's office) that can provide follow-up treatment and referrals.

Your costs if you have Original Medicare

You pay nothing for this test if your doctor accepts assignment.



Diabetes screening and self-management training

Diabetes is a medical condition in which your body doesn't make enough insulin, or has a reduced response to insulin. Diabetes causes your blood sugar to be too high because your body needs insulin to use sugar properly. A high blood sugar level isn't good for your health. Medicare covers a blood screening test to check for diabetes for people at risk. For people with diabetes, Medicare covers educational training to help manage their diabetes.

Diabetes screening (fasting blood glucose test)

Who's covered?

People who are at risk for diabetes and get a referral from a doctor.

How often is it covered?

Based on the results of your screening tests, you may be eligible for up to 2 diabetes screenings per year.

Your costs if you have Original Medicare

You pay nothing for this screening.

Diabetes screening and self-management training (continued)

Am I at risk for diabetes?

You're considered at risk if you have high blood pressure, dyslipidemia (history of abnormal cholesterol and triglyceride levels), obesity, or a history of high blood sugar (glucose). Medicare also covers these tests if 2 or more of these apply to you:

- You're 65 or older.
- You're overweight.
- You have a family history of diabetes (parents, brothers, or sisters).
- You have a history of gestational diabetes (diabetes during pregnancy), or you've had a baby weighing more than 9 pounds.

Diabetes self-management training

Who's covered?

This training is for people with diabetes to teach them to manage their condition and prevent complications. You need a written order from a doctor or other qualified health care provider.

Your costs if you have Original Medicare.

You pay 20% of the Medicare-approved amount after the yearly Part B deductible.



Flu shot – See “Shots” on page 18.



Glaucoma tests

Glaucoma is an eye disease caused by high pressure in the eye. It can develop gradually without warning and often without symptoms. The best way for people at high risk for glaucoma to protect themselves is to have regular eye exams.

Who's covered?

People with Medicare at high risk for glaucoma.

How often is it covered?

Once every 12 months.

Your costs if you have Original Medicare

You pay 20% of the Medicare-approved amount after the yearly Part B deductible.

Glaucoma tests (continued)

Am I at high risk for glaucoma?

Your risk for glaucoma increases if any of these are true:

- You have diabetes.
- You have a family history of glaucoma.
- You're African-American and 50 or older.
- You're Hispanic and 65 or older.



Hepatitis B Virus (HBV) infection screening

Who's covered?

Medicare covers HBV infection screenings if you meet one of these conditions:

- You're at high risk for HBV infection.
- You're pregnant.

Medicare will only cover HBV infection screenings if they're ordered by a primary care provider.

How often is it covered?

HBV infection screenings are covered:

- Annually only for those with continued high risk who don't get a Hepatitis B vaccination.
- For pregnant women:
 - At the first prenatal visit for each pregnancy.
 - At the time of delivery for those with new or continued risk factors.
 - At the first prenatal visit for future pregnancies, even if you previously got the Hepatitis B shot or had negative HBV screening results.

Your costs if you have Original Medicare

You pay nothing for the screening test if the doctor accepts assignment.



Hepatitis C screening test

Who's covered?

You're covered if you meet at least **one** of these conditions:

- You're at high risk because you have a current or past history of illicit injection drug use.
- You're at high risk because you had a blood transfusion before 1992.
- You were born between 1945-1965.

How often is it covered?

Medicare covers a one-time Hepatitis C screening test. Medicare also covers a repeat screening yearly for certain people at high risk.

Your costs if you have Original Medicare

You pay nothing for the screening test if it's ordered by a primary care provider who accepts assignment.



HIV screening

Medicare covers HIV (Human Immunodeficiency Virus) screenings if you meet these conditions:

- You're 15–65, not at risk and ask for the screening.
- You're younger than 15 or older than 65, at an increased risk for the virus, and ask for the screening.

How often is it covered?

Medicare covers this test once every 12 months, or up to 3 times during a pregnancy.

Your costs if you have Original Medicare

You pay nothing for this test.



Lung cancer screening

Who's covered?

Medicare covers lung cancer screening with Low Dose Computed Tomography (LDCT) if you meet all of these:

- You're 55–77.
- You're asymptomatic (you don't have signs or symptoms of lung cancer).
- You're either a current smoker or have quit smoking within the last 15 years.

Lung cancer screening (continued)

- You have a tobacco smoking history of at least 30 “pack years” (an average of one pack a day for 30 years).
- You have a written order from your doctor or qualified non-physician practitioner.
 - (Before your first lung cancer screening, you’ll need to schedule an appointment with your doctor to discuss the benefits and risks of lung cancer screening. You and your doctor can decide whether lung cancer screening is right for you.)
- The service is provided by a reading radiologist at an appropriate radiology imaging center that meets Medicare standards.

How often is it covered?

Once every 12 months.

Your costs if you have Original Medicare

You pay nothing for this service if the primary care doctor or other qualified primary care practitioner meets the appropriate standards and accepts assignment.



Medical nutrition therapy

Medicare may cover medical nutrition therapy (MNT) services and certain related services if you have diabetes or kidney disease, or you’ve had a kidney transplant in the last 36 months. Your doctor or other qualified practitioner must refer you for the MNT service. A Registered Dietitian or nutrition professional who meets certain requirements can provide MNT services. Services may include an initial nutrition and lifestyle assessment, one-on-one nutritional counseling, help managing the lifestyle factors that affect your diabetes, and follow-up visits to check on your progress in managing your diet. If you get dialysis in a dialysis facility, Medicare covers MNT as part of your overall dialysis care.

Who’s covered?

Certain people who have any of these:

- Diabetes
- Renal disease (people who have kidney disease, but aren’t on dialysis)
- Have had a kidney transplant within the last 3 years

Your doctor needs to refer you for this service.

Medical nutrition therapy (continued)

How often is it covered?

Medicare covers 3 hours of one-on-one counseling services the first year, and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's referral. A doctor must prescribe these services and renew your referral yearly if your treatment needs to continue into another calendar year.

Your costs if you have Original Medicare

You pay nothing for these services if the doctor accepts assignment.

For more information about diabetes and medical nutrition therapy

Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view the booklet "Medicare Coverage of Diabetes Supplies & Services." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.



Medicare Diabetes Prevention Program

Medicare covers a once-per-lifetime proven health behavior change program to help you prevent type 2 diabetes.

Who's covered?

You must have:

- Medicare Part B.
- A hemoglobin A1c test result between 5.7 and 6.4%, a fasting plasma glucose of 110-125mg/dL, or a 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerant test) within 12 months of attending the first core session.
- A body mass index (BMI) of 25 or more (BMI of 23 or more if you're Asian).
- Never been diagnosed with type 1 or type 2 diabetes or End-Stage Renal Disease (ESRD).
- Never participated in the Medicare Diabetes Prevention Program.

How often is it covered?

The program begins with 16 core sessions offered in a group setting over a 6-month period. Once you complete the core sessions, you'll get 6 more months of less intensive monthly follow-up sessions to help you maintain healthy habits. You'll also get an additional 12 months of ongoing maintenance sessions if you meet certain weight loss and attendance goals.

Your costs if you have Original Medicare

You pay nothing for these services if eligible.



Obesity screening and counseling

Medicare covers intensive behavioral therapy for people with obesity, defined as a body mass index (BMI) of 30 or more.

Who's covered?

All people with Medicare may be screened for obesity. Counseling is covered for anyone found to have a BMI of 30 or more.

How often is it covered?

Medicare covers behavioral therapy sessions to help you lose weight. This counseling may be covered if you get it in a primary care setting (like a doctor's office), where it can be coordinated with your other care and a personalized prevention plan.

Your costs if you have Original Medicare

You pay nothing for this service if your primary care doctor or other qualified primary care practitioner accepts assignment.



Pneumococcal shot – See “Shots” on page 18.



Prostate cancer screening

Prostate cancer may be found by testing the amount of PSA (Prostate Specific Antigen) in your blood. Your doctor can also find prostate cancer during a digital rectal exam. Medicare covers both of these tests.

Who's covered?

All men with Medicare over 50 (coverage for this test begins the day after their 50th birthday).

How often is it covered?

- Digital rectal examination—Once every 12 months.
- PSA test—Once every 12 months.

Your costs if you have Original Medicare

Generally, you pay 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. You pay nothing for the PSA test.

Am I at high risk for prostate cancer?

Talk to your doctor about whether you're at risk for prostate cancer.



Sexually transmitted infection screenings and counseling

Medicare covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and/or Hepatitis B.

Who's covered?

People with Medicare who are pregnant and/or certain people who are at increased risk for an STI when a primary care doctor or other qualified primary care practitioner orders the screening tests and provides counseling.

How often is it covered?

Medicare covers these tests once every 12 months or at certain times during pregnancy. Medicare also covers up to 2 individual 20 to 30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Medicare will only cover these counseling sessions if they're provided by a primary care provider and take place in a primary care setting (like a doctor's office). Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive service.

Your costs if you have Original Medicare

You pay nothing for these services if your primary care doctor or other qualified primary care practitioner accepts assignment.



Shots (flu, pneumococcal, and Hepatitis B)

Medicare covers flu, pneumococcal, and Hepatitis B shots. Flu, pneumococcal infections, and Hepatitis B can be life threatening to an older person. All people 65 and older should get flu and pneumococcal shots. People with Medicare who are under 65 should also get a flu shot. This is especially important for those who have chronic illness, including heart disease, lung disease, diabetes, or End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant). People at medium to high risk for Hepatitis B should get Hepatitis B shots.

Shots (flu, pneumococcal, and Hepatitis B) (continued)

Flu shot

Who's covered?

All people with Medicare.

How often is it covered?

Once each flu season.

Your costs if you have Original Medicare

You pay nothing if your doctor or other qualified health care provider accepts assignment for giving the shot.

Pneumococcal shot

Who's covered?

All people with Medicare.

How often is it covered?

Most people only need one shot once in their lifetime. A different, second shot, is covered 11 months after you get the first shot. Talk with your doctor or other qualified health care provider to see if you need these shots.

Your costs if you have Original Medicare

You pay nothing if your doctor or other qualified health care provider accepts assignment for giving the shot.

Hepatitis B shots

Who's covered?

Certain people with Medicare who are at medium or high risk for Hepatitis B.

How often is it covered?

Three shots are needed for complete protection. Check with your doctor about when to get these shots if you qualify to get them.

Your costs if you have Original Medicare

You pay nothing if your doctor or other qualified health care provider accepts assignment.

Shots (flu, pneumococcal, and Hepatitis B) (continued)

Hepatitis B shots (continued)

Am I at medium or high risk for Hepatitis B?

These are some of the factors that put you at medium or high risk for Hepatitis B:

- Hemophilia.
- ESRD (End-Stage Renal Disease).
- Diabetes.
- Certain other conditions that increase your risk for infection, like if you live with someone who has Hepatitis B, or if you're a health care worker and have frequent contact with blood or body fluids.

Other factors may increase your risk for Hepatitis B. Check with your doctor to see if you're at medium or high risk for Hepatitis B.



Smoking and tobacco use cessation counseling

The U.S. Surgeon General has reported that quitting smoking and stopping other forms of tobacco use lead to significant risk reduction for certain diseases and other health benefits, even in older adults who've smoked for years. Any person who uses tobacco can get counseling from a qualified doctor or other Medicare-recognized practitioner who can help them stop using tobacco.

Who's covered?

People with Medicare who use tobacco.

How often is it covered?

Medicare will cover up to 8 face-to-face visits during a 12-month period. These visits must be provided by a qualified doctor or other Medicare-recognized practitioner.

Your costs if you have Original Medicare

You pay nothing for the counseling sessions.

Ask your doctor about Medicare-covered tobacco cessation programs near you, or visit nih.gov for more information about stopping tobacco use.



“Welcome to Medicare” preventive visit

Medicare covers a one-time preventive visit within the first 12 months that you have Medicare Part B (Medical Insurance). This visit is called the “Welcome to Medicare” preventive visit. The visit is a great way to get up-to-date on important screenings and shots and to talk with your doctor about your family history and how to stay healthy.

What happens during the visit?

During the visit, your doctor will:

- Record your medical and social history (like alcohol or tobacco use, your diet, and your activity level).
- Check your height, weight, and blood pressure.
- Calculate your body mass index (BMI).
- Give you a simple vision test.
- Review your potential risk for depression and your level of safety.
- Offer to talk with you about creating advance directives. Advance directives are legal documents that allow you to put in writing what kind of health care you would want if you were too ill to speak for yourself.

Depending on your general health and medical history, your doctor will review your medical and social history related to your health, and education and counseling about preventive services. Your doctor will also give you a written plan (like a checklist) letting you know what screenings, shots, and other preventive services you need.

What should I bring to the visit?

When you go to your “Welcome to Medicare” preventive visit, bring these items:

- Your medical records, including immunization records (if you’re seeing a new doctor). Call your old doctor to get copies of your medical records.
- Your family health history. Try to learn as much as you can about your family’s health history before your appointment. Any information you can give your doctor can help determine if you’re at risk for certain diseases.
- A list of prescription and over-the-counter drugs that you currently take, how often you take them, and why.

Who’s covered, and how often is it covered?

This visit is only covered one time, and you must have the visit within the first 12 months you’re enrolled in Part B.

Your costs if you have Original Medicare

You pay nothing if your doctor accepts assignment.



Yearly “Wellness” visit

If you’ve had Medicare Part B (Medical Insurance) for longer than 12 months, you can get a yearly “Wellness” visit to develop or update a personalized prevention plan based on your current health and risk factors. This includes:

- Health risk assessment (Your doctor or health professional will ask you to answer some questions before or during your visit, which is called a health risk assessment. Your responses to the questions will help you and your health professional get the most from your yearly “Wellness” visit.)
- Review of medical and family history.
- Develop or update a list of current providers and prescriptions.
- Height, weight, blood pressure, and other routine measurements.
- Detection of any cognitive impairment.
- Personalized health advice.
- A list of risk factors and treatment options for you.
- A screening schedule (like a checklist) for appropriate preventive services.

How often is it covered?

Once every 12 months.

Your costs if you have Original Medicare

You pay nothing for this visit if your doctor accepts assignment.

You don’t need to have had a “Welcome to Medicare” preventive visit before getting a yearly “Wellness” visit. If you get the “Welcome to Medicare” preventive visit during your first year with Part B, you’ll have to wait 12 months before you can get your first yearly “Wellness” visit.

For more information about Medicare preventive services

You can learn more about Medicare’s preventive services by visiting [Medicare.gov](https://www.Medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

CMS Accessible Communications

To help ensure people with disabilities have an equal opportunity to participate in our services, activities, programs, and other benefits, we provide communications in accessible formats. The Centers for Medicare & Medicaid Services (CMS) provides free auxiliary aids and services, including information in accessible formats like Braille, large print, data/audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format you can:

1. **Call us:** For Medicare: 1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048.
2. **Email us:** altformatrequest@cms.hhs.gov.
3. **Send us a fax:** 1-844-530-3676.
4. **Send us a letter:**

Centers for Medicare & Medicaid Services
Offices of Hearings and Inquiries (OHI)
7500 Security Boulevard, Mail Stop S1-13-25
Baltimore, MD 21244-1850
Attn: Customer Accessibility Resource Staff

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Medicare Prescription Drug Plan, contact your plan to request its information in an accessible format. For Medicaid, contact your State or local Medicaid office.

To help ensure people with disabilities have an equal opportunity to participate in our services, activities, programs, and other benefits, we provide communications in accessible formats. The Centers for Medicare & Medicaid Services (CMS) provides free auxiliary aids and services, including information in accessible formats like Braille, large print, data/audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare Prescription Drug Plan, State or local Medicaid office, or Marketplace Qualified Health Plans. There are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. **Online:** hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.
2. **By phone:** Call 1-800-368-1019. TTY users can call 1-800-537-7697.
3. **In writing:** Send information about your complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

**U.S. DEPARTMENT OF HEALTH AND
HUMAN SERVICES**

Centers for Medicare & Medicaid Services

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CMS Product No. 10110
Revised August 2019

