Ex: Non-FQHC provider, Screening Procedure Recheck

[redacted]

DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

Managed Care

STAPLE HERE

PLEASE PRINT

PATIENT NAME (LAST)	(FIRST)	(INITIAL)	MEDICAL RECORD NO.	L.A. Code
Johnson	Anna	D		

BIRTHDATE Mo. Day Year	AGE	SEX M/F	PATIENT'S COUNTY OF RESIDENCE	CO. CODE	TELEPHONE NUMBER	NEXT CHDP EXAM Mo. Day Year	Ethnic Code
02 14 10	3Y	F	San Francisco	38	(415) 555-5555		7

Ethnic Code: 1-American Indian, 2-Asian, 3-Black, 4-Filipino, 5-Mex. Amer./Hispanic, 6-White, 7-Other, 8-Pacific Islander

RESPONSIBLE PERSON (NAME)	(STREET)	(APT/SPACE #)	(CITY)	(ZIP)
Johnson, Gloria	95 Wildwood Way	#A	San Francisco	94111

CHDP ASSESSMENT

Indicate outcome for each screening procedure

DATE OF SERVICE Mo. Day Year: 04 25 13

FOLLOW UP CODES
1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED

	NO PROBLEM SUSPECTED √A	REFUSED, CONTRA-INDICATED, NOT NEEDED √B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column: NEW C	KNOWN D	FEES
01 HISTORY and PHYSICAL EXAM					01
02 DENTAL ASSESSMENT/REFERRAL					
03 NUTRITIONAL ASSESSMENT					
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION					
05 DEVELOPMENTAL ASSESSMENT					
06 SNELLEN OR EQUIVALENT	√				06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT					08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					12

REFERRED TO: | TELEPHONE NUMBER

REFERRED TO: | TELEPHONE NUMBER

COMMENTS/PROBLEMS

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

06 passed both eyes (recheck)

CODE	OTHER TESTS	PLEASE REFER TO THE CHDP LIST OF TEST CODES	CODE	OTHER TESTS

HEIGHT IN INCHES	WEIGHT LBS OZS	BODY MASS INDEX (BMI) PERCENTILE	BLOOD PRESSURE
04		%	

HEMOGLOBIN	HEMATOCRIT	BIRTH WEIGHT LBS OZS
	.0%	

INFORMATION ONLY REPORTING

ROUTINE REFERRAL(S) (√): ☐ BLOOD LEAD ☐ DENTAL

PATIENT IS A FOSTER CHILD (√): ☐

DIAGNOSIS CODES: 1 | 2

IMMUNIZATIONS

PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

	GIVEN TODAY: NOW UP TO DATE FOR AGE A	GIVEN TODAY: STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	NOT GIVEN TODAY: REFUSED OR CONTRA-INDICATED D

THE QUESTIONS BELOW MUST BE ANSWERED

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ☐
2. Tobacco Used by Patient Yes ☐ No ☐
3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes ☐ No ☐

PATIENT VISIT (√)	TYPE OF SCREEN (√)	TOTAL FEES
1 New Patient or Extended Visit ☐ 2 Routine Visit ☐	1 Initial ☐ 2 Periodic ☐	

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)

HEALTH PLAN CODE / PROVIDER NUMBER: Health plan code here

PLACE OF SERVICE: 11

1 Enrolled in WIC 2 Referred to WIC

NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY	COUNTY	AID	IDENTIFICATION NUMBER
	38	3N	Medi-Cal CIN# only

JoAnne Staywell, MD
555 Main Street
San Francisco, CA 94102-4444
(415) 555-1111

San Francisco Health Plan
201 Third St, 7th Floor
San Francisco, CA 94103
415-615-4257

RENDERING PROVIDER (PRINT NAME):

Signature of Provider here — SIGNATURE OF PROVIDER

04/25/2013 — DATE

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

COPY 1 - MAIL TO MEDI-CAL CHDP

PM 160 INFORMATION ONLY (03/07)

CONFIDENTIAL SCREENING/BILLING REPORT