[redacted]

DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

STAPLE HERE

PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (INITIAL) | MEDICAL RECORD NO. | L.A. Code 94102104848 J

BIRTHDATE Mo. Day Year | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Mo. Day Year

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE #) (CITY) (ZIP)

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

CHDP ASSESSMENT

Indicate outcome for each screening procedure

	NO PROBLEM SUSPECTED ✓A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column: NEW C	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column: KNOWN D	DATE OF SERVICE Mo. Day Year / 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

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

REFERRED TO: | TELEPHONE NUMBER

REFERRED TO: | TELEPHONE NUMBER

COMMENTS/PROBLEMS

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

CODE	OTHER TESTS	CODE	OTHER TESTS

PLEASE REFER TO THE CHDP LIST OF TEST CODES

HEIGHT IN INCHES 0 4 | WEIGHT LBS OZS | BODY MASS INDEX (BMI) PERCENTILE | BLOOD PRESSURE

HEMOGLOBIN | HEMATOCRIT .0% | % | BIRTH WEIGHT LBS OZS

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

PATIENT IS A FOSTER CHILD (✓) ☐

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

DIAGNOSIS CODES 1 | 2

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 (✓): 1 New Patient or Extended Visit | 2 Routine Visit

TYPE OF SCREEN (✓): 1 Initial | 2 Periodic

TOTAL FEES

1 Enrolled in WIC 2 Referred to WIC

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

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

PROVIDER NUMBER | PLACE OF SERVICE

1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY: COUNTY | AID | IDENTIFICATION NUMBER

SITE OF SERVICE IF OTHER THAN ABOVE:

1 ✓ If covered by Medi-Cal, or pre-enrolled in CHDP Gateway, enter BIC number.

2 ✓ Patient eligible for CHDP benefits only.

This is to certify that the screening information is true and complete, and the results explained to the child or his parent or guardian. I understand that payment and satisfaction of this claim may be from Federal or State funds, and that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable Federal or State law. I also certify that none of the services billed on this form have been or will be billed to Medi-Cal, the patient, or other insurance providers.

SIGNATURE OF PROVIDER | 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

CONFIDENTIAL SCREENING/BILLING REPORT

PM 160 (3/07)

Listed below are Place of Service (POS) Codes and Corresponding Descriptions to be used when Billing CHDP services

POS Code	Description
11	Office (any location other than Place of Service code 22 or 71)
22	Outpatient Hospital
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other

RELEASE OF INFORMATION NOTICE TO THE RESPONSIBLE PERSON:

The information provided on this form is voluntary and is used by the California Child Health and Disability Prevention (CHDP) program in accordance with Article 7, Subchapter 13, Title 17, of the California Administrative Code to monitor program quality, to reimburse providers of health assessments for their services, and to facilitate diagnosis and treatment at the local level for children found to have health problems. Information provided may be transferred to local health departments for follow-ups. Refusal to supply the information requested will hamper efforts to monitor this program, may delay reimbursement procedures, and may delay diagnosis and treatment of health conditions affecting your child. For access to records containing this information, you may contact the individual listed below. You may also request the location of this information and the categories of persons who use it.

Chief, Children's Medical Services
Department of Health Care Services
MS 8100
1515 K Street, Suite 400
Sacramento, CA 95814

(916) 327-1400