

DO NOT STAPLE
IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY



PLEASE PRINT	PATIENT NAME (LAST) (FIRST) (INITIAL)			MEDICAL RECORD NO.		L.A. Code	
	Mo.	BIRTH DATE Day Year	AGE	SEX M/F	PATIENT'S COUNTY OF RESIDENCE	CO. CODE	TELEPHONE NUMBER
	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	REFUSED, CONTRA-INDICATED, NOT NEEDED	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column		DATE OF SERVICE	FOLLOW UP CODES	
	√ A	√ B	NEW C	KNOWN D	Mo. Day Year		
01 HISTORY and PHYSICAL EXAM					01	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.	
02 DENTAL ASSESSMENT/REFERRAL						REFERRED TO: TELEPHONE NUMBER	
03 NUTRITIONAL ASSESSMENT						REFERRED TO: TELEPHONE NUMBER	
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION						COMMENTS/PROBLEMS IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA	
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		
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	INFORMATION ONLY REPORTING
0	4				
HEMOGLOBIN	HEMATOCRIT		BIRTH WEIGHT LBS	OZS	
		0%			
IMMUNIZATIONS PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES		GIVEN TODAY	NOT GIVEN TODAY		
		NOW UP TO DATE FOR AGE A	STILL NOT UP TO DATE FOR AGE B	ALREADY UP TO DATE FOR AGE C	REFUSED OR CONTRA-INDICATED D

ROUTINE REFERRAL(S) (√)	PATIENT IS A FOSTER CHILD (√)
BLOOD LEAD	DENTAL
1	2

PATIENT VISIT (√)	TYPE OF SCREEN (√)	TOTAL FEES
1-New Patient or Extended-Visit	1-Initial	
2-Routine-Visit	2-Periodic	
PROVIDER OF SERVICE: Name, Address, Telephone Number (Please Include Area Code)	HEALTH PLAN CODE / PROVIDER NUMBER	PLACE OF SERVICE
RENDERING PROVIDER (PRINT NAME):		
SIGNATURE OF PROVIDER	DATE	

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

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

CONFIDENTIAL SCREENING/BILLING REPORT

COPY 1 - MAIL TO MEDI-CAL CHDP

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

PM 160 INFORMATION ONLY (03/07)

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

<u>POS Code</u>	<u>Description</u>
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