INCOMPLETE VISION SCREENING

[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.	LA. Code	
SMITH	JANE	L	987654321 0	05	94 09446785 J

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
01 25 04	3y	F	COUNTY	19	(805)555-1234	07 01 08	6

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)
AMY SMITH	1234 MAPLE LANE		TOWN	90212

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	KNOWN D	DATE OF SERVICE Mo. Day Year: 07 01 07 FEES
01 HISTORY and PHYSICAL EXAM	✓				01 39.00
02 DENTAL ASSESSMENT/REFERRAL	✓				
03 NUTRITIONAL ASSESSMENT	✓				
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION	✓				
05 DEVELOPMENTAL ASSESSMENT	✓				
06 SNELLEN OR EQUIVALENT		✓			06
07 AUDIOMETRIC	✓				07 11.60
08 HEMOGLOBIN OR HEMATOCRIT	✓				08 3.01
09 URINE DIPSTICK	✓				09 2.87
10 COMPLETE URINALYSIS		✓			10
12 TB MANTOUX		✓			12

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

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

06 Child unable to follow directions
Recheck scheduled 11/05/07, 3:30 PM

HEIGHT IN INCHES	WEIGHT LBS	OZS	BODY MASS INDEX (BMI) PERCENTILE	BLOOD PRESSURE
037 0/4	032	05	75 %	/

HEMOGLOBIN	HEMATOCRIT	BIRTH WEIGHT LBS	OZS
121	.0%		

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	STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	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 (✓)	TYPE OF SCREEN (✓)	TOTAL FEES
1 New Patient or Extended Visit; ☑ 2 Routine Visit	1 Initial; ☑ 2 Periodic	56.48

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

PROVIDER NUMBER	PLACE OF SERVICE
NPINUMBER	11

Your Facility / Provider Name
Your Street Address
City, State, 9-digit Zip Code
Your Telephone Number

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
	19	BW	5458436091

✓ 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.

Examiner Signature — SIGNATURE OF PROVIDER
07/01/07 — DATE

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

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

CONFIDENTIAL SCREENING/BILLING REPORT

COPY 1 - MAIL TO MEDI-CAL CHDP

PM 160 (3/07)