

DO NOT STAPLE  
IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

7  
STAPLE  
HERE

PLEASE PRINT	PATIENT NAME (LAST) (FIRST) (INITIAL)			MEDICAL RECORD NO.	L.A. Code			
	BRIAN LIZA S			OPTIONAL	NA			
1	BIRTHDATE	AGE	SEX M/F	PATIENT'S COUNTY OF RESIDENCE	CO. CODE	TELEPHONE NUMBER	NEXT CHDP EXAM	Ethnic Code
	Mo. 07   Day 14   Year 01	12 Mos.	F	LOS ANGELES	19	(213) 555-1234	Mo. 07   Day 31   Year 02	
RESPONSIBLE PERSON (NAME)		(STREET)		(APT./SPACE #)	(CITY)	(ZIP)		
ALICIA BRIAN		1234 RAYMOND AVE.		APT. #5	LOS ANGELES	90007		

<b>CHDP ASSESSMENT</b> 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. 07   Day 22   Year 02	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.

01 HISTORY and PHYSICAL EXAM			3	1	01
02 DENTAL ASSESSMENT/REFERRAL			5		
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			3		09
10 COMPLETE URINALYSIS	✓				10
12 TB MANTOUX		✓			12

REFERRED TO:	PATIENT'S PROVIDER	TELEPHONE NUMBER	PROVIDER #
REFERRED TO:		TELEPHONE NUMBER	

**COMMENTS/PROBLEMS**  
IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

PRIMARY LANGUAGE - SPANISH

01- OTITIS MEDIA (3)

INNOCENT HEART MURMUR (1)

02- DENTAL CARIES (5)

08- ANEMIA (3)

15- 7mcg/dl

HEIGHT IN INCHES	WEIGHT	BLOOD PRESURE
0 35 3/4	0 29 06	/
HEMOGLOBIN	HEMATOCRIT	BIRTH WEIGHT
0 8 5	0%	0 7 0 2

ROUTINE REFERRALS (S) (✓)	PATIENT IS A FOSTER CHILD (✓)
<input type="checkbox"/> BLOOD LEAD	<input type="checkbox"/> DENTAL

IMMUNIZATIONS PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES	GIVEN TODAY		NOT GIVEN TODAY	
	NOW UP TO DATE FOR AGE	STILL NOT UP TO DATE FOR AGE	ALREADY UP TO DATE FOR AGE	REFUSED OR CONTRA-INDICATED
39 POLIO - ORAL			✓	
33 MMR - VFC			✓	

ICD 9 CODES		
1	2	3
3 8 2 . 0 0	7 8 5 . 2 0	5 2 1 . 0 0

**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

2. Counseled About/Referred For Tobacco Use Prevention/Cessation. Yes  No

PATIENT VISIT (✓)	TYPE OF SCREEN (✓)	TOTAL FEES
<input type="checkbox"/> 1 New Patient or Extended Visit	<input type="checkbox"/> 1 Initial	
<input type="checkbox"/> 2 Routine Visit	<input type="checkbox"/> 2 Periodic	

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

L. A. CARE HEALTH PLAN

555 WEST FIFTH ST

18TH FLOOR

LOS ANGELES

CA 90013

PREPAID PROJECT CODE/PROVIDER NUMBER: 3 0 4

Enrolled in WIC  Referred to WIC

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

1 PARTIAL SCREEN  2 SCREENING PROCEDURE RECHECK

5

RENDERING PROVIDER (PRINT NAME):

PROVIDER'S LICENSE#

PROVIDER'S NAME

PROVIDER'S ADDRESS

PROVIDER'S PHONE#

Don't forget to sign

Put name of Health Plan here

SIGNATURE OF PROVIDER: *Liza Brian*

DATE: 7/22/02

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY	COUNTY	AID	IDENTIFICATION NUMBER
	19	30	999999999

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 110 INFORMATION ONLY (7/03)

CONFIDENTIAL SCREENING/BILLING REPORT

## How to Complete the PM 160 (version 07/03)

A PM 160 must be completed for all well visits for Medi-Cal members under the age of 21. Please fill out each PM160 completely, using the guidelines below.

### Section 1 - Demographic Information

- ▶ Please fill in all information on the member and their responsible person.
- ▶ Record the member's age in months up to the age of 2 years (24 months).
- ▶ PM160s that do not record the date of service will be returned.

### Section 2 - Assessment Information

- ▶ Fill out information relating to the assessment completely, making sure to insert the proper follow-up in Columns C and D. Checks in these columns will not be accepted.
- ▶ Record member's height in feet and inches; weight in pounds and ounces. Metric measurements are not acceptable.
- ▶ Record head circumference up to 24 months. Head circumference can be recorded in the area on the left of the height and hemoglobin areas.
- ▶ Blood pressure must be recorded at every visit after the age of 3 years.
- ▶ Urinalysis or urine dipstick is needed; not both.
- ▶ Hemoglobin or Hematocrit is needed; both are not necessary.
- ▶ The Mantoux TB test is to be used; multipuncture is not acceptable.
- ▶ Birthweight should be recorded up to 24 months.
- ▶ Code 15 - Blood level outcome for lead level must be given in comments section.

### Section 3 - Immunization Information

- ▶ One column (A, B, C or D) should be filled in for each immunization.
- ▶ If an immunization is given, the number of the series should be recorded in Column A or B as appropriate.
- ▶ Checks should be recorded in Columns C or D if an immunization is not given.
- ▶ Preprinted immunizations previously listed on the PM160 have been removed and replaced with blank lines. This will permit you to indicate all the vaccines administered during one CHDP health assessment on one form.
- ▶ Record the series number of the immunization on all PM160s; this is not restricted to 0-24 months only.

### Section 4 - Referral Information

- ▶ List diagnoses to correspond with assessment findings from Section 2. Use follow-up codes as listed.
- ▶ Members should be referred for dental services at every visit, beginning at the age of 3.
- ▶ Enter the patient's Dental Plan provider name and phone number in the 'Referred To' and 'Telephone Number' boxes.
- ▶ List all appropriate ICD-9 codes. If more space is needed, list codes in the comments/problems area. An ICD-9 code must be entered in the box even if no illnesses are present; a V20.2 code for a 'routine child health visit' may be appropriate.

### Section 5 - Physician Information

- ▶ The prepaid project code for LA Care, Care 1<sup>st</sup>, CHP, UHP and Blue Cross is 304. The prepaid project code for Health Net, Molina and Universal is 352.
- ▶ Left justify the numbers in the space provided. Do not use Medi-Cal numbers.
- ▶ Enter LA Care or Health Net's name and address in the 'Provider of Service' section if it is not already there. The name of the actual health plan should be written under the prepaid project code box.
- ▶ Print or stamp the name of the rendering provider in the area labeled 'Rendering Provider'. The provider's medical license number, address and telephone number should also be documented in this area.
- ▶ The PM160 must be signed by the provider of service. Any other signatures will not be accepted.
- ▶ Partial Screenings must be marked if patient needs to come back to complete physical and a date of return must be entered.
- ▶ List member's Medi-Cal number, including county and aid codes. The member identification number should be taken from the patient's Medi-Cal BIC card (10 digits).