CalViva HEALTH™ | Health Net® COMMUNITY SOLUTIONS

PM 160 INF Form

Quick Tips

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

DO NOT STAPLE IN BAR AREA

STAPLE HERE

PATIENT NAME (LAST) (FIRST) (INITIAL) MEDICAL RECORD NO. I.A. Code

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 KNOWN D | DATE OF SERVICE Mo. Day Year | FEES

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

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01 HISTORY and PHYSICAL EXAM
02 DENTAL ASSESSMENT/REFERRAL
03 NUTRITIONAL ASSESSMENT
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION
05 DEVELOPMENTAL ASSESSMENT
06 SNELLEN OR EQUIVALENT
07 AUDIOMETRIC
08 HEMOGLOBIN OR HEMATOCRIT
09 URINE DIPSTICK
10 COMPLETE URINALYSIS
12 TB MANTOUX
CODE OTHER TESTS PLEASE REFER TO THE CHDP LIST OF TEST CODES

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

HEIGHT IN INCHES | WEIGHT LBS OZS | BODY MASS INDEX (BMI) PERCENTILE | BLOOD PRESSURE
HEMOGLOBIN | HEMATOCRIT % | BIRTH WEIGHT LBS OZS

INFORMATION ONLY REPORTING

Counseled/Discussed Physical Activity Yes No

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

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code) | HEALTH PLAN CODE/PROVIDER NUMBER | PLACE OF SERVICE

NPI# 9999999999
Health Net
PO BOX 419071
Rancho Cordova, CA 95741

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

RENDERING PROVIDER (PRINT NAME):

SIGNATURE OF PROVIDER DATE

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

CONFIDENTIAL SCREENING/BILLING REPORT

PM 160 INFORMATION ONLY (03/07)

A B C 1 2 3

Submit the PM 160 INF form to the Encounter Department by the 10th day of each month for the previous month's Child Health and Disability Prevention (CHDP).

Submitting PM 160 INF forms electronically is preferred; however, Health Net does accept paper PM 160 INF forms. Providers must mail completed paper PM 160 INF forms to the following address:

CalViva Health
Health Net
PO Box 419071
Rancho Cordova, CA 95741

Complete each PM 160 Information Only (INF) form in its entirety. Use only black ink to complete all fields and press hard to ensure all four copies of the form are legible. Type or write clearly, especially the patient identification number and date of service. Do not use staples or attachments.

Submit PM 160 INF forms electronically by logging in to provider.healthnet.com and selecting *Transactions* > *Claims* > *Submit PM 160 INF Form.*

If your office uses an electronic database for PM 160 INF information, contact the Encounter Department for electronic submission at ENC_Team@healthnet.com.

The PM 160 INF form will be rejected if the following three fields are not complete. Providers must:

A. Enter the date of service.

B. Enter the National Provider Identifier (NPI).

C. Enter the member identification number.

The following fields must be completed for timely processing:

1. Next CHDP exam.
2. Body mass index (BMI) percentile and blood pressure for a child older than age three.
3. Height and weight for all ages.

(continued)

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PLEASE PRINT

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

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

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REFERRED TO: TELEPHONE NUMBER

REFERRED TO: TELEPHONE NUMBER

COMMENTS/PROBLEMS

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

Counseled/Discussed Physical Activity — Yes — No (4)

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

HEMOGLOBIN | HEMATOCRIT .0% | % | BIRTH WEIGHT LBS OZS (5)

INFORMATION ONLY REPORTING

ROUTINE REFERRAL(S) (√) BLOOD LEAD, DENTAL | PATIENT IS A FOSTER CHILD (√)

DIAGNOSIS CODES 1 2 (6)

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

THE QUESTIONS BELOW MUST BE ANSWERED
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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 (√) Initial, 2 Periodic (7) | TOTAL FEES

1 Enrolled in WIC 2 Referred to WIC
NOTE: WIC requires Ht, Wt, and Hemoglobin/Hematocrit

1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK (9)
ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY COUNTY AID IDENTIFICATION NUMBER

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code) | HEALTH PLAN CODE/PROVIDER NUMBER (8) | PLACE OF SERVICE

NPI# 9999999999
Health Net
PO BOX 419071
Rancho Cordova, CA 95741

RENDERING PROVIDER (PRINT NAME): (10)

SIGNATURE OF PROVIDER DATE

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STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

PM 160 INFORMATION ONLY (03/07)

4. Check the appropriate box in the Comments section to indicate whether you counseled/discussed physical activity with the patient or responsible party.
5. Birth weight for a child younger than 25 months.
6. An ICD-9 code must be entered in the Diagnosis Codes box even if no illnesses are present. For example, a V202 code for a "routine visit or child health check" may be appropriate.
7. Check the applicable box for Type of Patient Visit and Type of Screen.
8. Enter the appropriate health plan code: Fresno – 315, Kings – 316, Madera – 317
9. If the PM 160 INF form is being completed for a visit that did not include a full exam, place an X in the Partial Screen box or Screening Procedure Re-Check box, as appropriate, and enter the last physical exam date in the Accompanies Prior PM 160 Dated field. In this case, blood pressure and height are not required.
10. Name and address of rendering provider.