



## PM 160 INF Form

## Quick Tips

DO NOT STAPLE IN BAR AREA		CLAIM	STAPLE HERE		
P PATIENT NAME (LAST)	(	IRST)	(INITIAL)	MEDICAL RECORD NO. L.A. Code	
BIRTHDATE AGE Mo. Day Year	SEX M/F PATIENT'S CO	JNTY OF RESIDENCE	CO.CODE TE	EPHONE NUMBER NEXT CHDP EXAM No. Day Year	1-American Indian
R RESPONSIBLE PERSON (NAME)		TREET)	(APT/SPACE #)	) (CITY) (ZIP)	1. American Indian 2. Asian 2. Asian 5. Black 4. Filipino 5. Mex. Amer./Hispanic 6. White 6. Pacific Islander
RESPONSIBLE PERSON (NAME)	(S	IREE1)	(APT/SPACE II)	(GIT) (ZIP)	6-White 7-Other 8-Pacific Islander
CHDP ASSESSMENT Indicate outcome for each screening procedure	NO PROBLEM NOT NEEDED	PROBLEM SUSPECTED Enter Follow Up Code In Appropriate Column NEW KNOWN C D	DATE OF SERVI	1 NO DX/RX INDICATED OR NOW 4.D. UNDER CARE. SI 2. QUESTIONABLE RESULT, RECHECK 5.R.	CODES X PENDINGRETURN VISIT CHEDULED. EFERRED TO ANOTHER EXAMINER OF DXRX. EFERRAL REFUSED
01 HISTORY and PHYSICAL EXAM			01	REFERRED TO:	TELEPHONE NUMBER
02 DENTAL ASSESSMENT/REFERRAL			UI	REFERRED TO:	TELEPHONE NUMBER
03 NUTRITIONAL ASSESSMENT 04 ANTICIPATORY GUIDANCE 14 HEALTH EDUCATION			_	COMMENTS/PRO	ADI EME
05 DEVELOPMENTAL ASSESSMENT				IF A PROBLEM IS DIAGNOSED THIS VI	
06 SNELLEN OR EQUIVALENT 07 AUDIOMETRIC			06	YOUR DIAGNOSIS IN TH	IS AREA
08 HEMOGLOBIN OR HEMATOCRIT			08		
09 URINE DIPSTICK 10 COMPLETE URINALYSIS			10		
12 TB MANTOUX			12 CODE OTHER TESTS		
CODE OTHER TESTS PLEASE RE	FER TO THE CHOP US	OF TEST CODES	CODE OTHER TESTS		
HEIGHT IN INCHES WEIGHT LBS 02	BODY MASS INDEX (BMI) PERCENTILE	BLOOD PRESSURE	INFORMATION	Counseled/Discussed Physical Activity	es No
HEMOGLOBIN HEMATOCRIT	0% %	BIRTH WEIGHT LBS OZS NOT GIVEN TODAY	ONLY REPORTING	ROUTINE REFERRAL(S) (√) PATIE  BLOOD LEAD DENTAL	NT IS A FOSTER CHILD (√)
MMUNIZATIONS PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES	NOW UP STILL NOT TO DATE FOR DATE FOR AGE AGE A B	ALREADY REFUSED OR OR CONTRA- AGE INDICATED D		DIAGNOSIS COI	2
				Patient is Exposed to Passive (Secon Hand) Tobacco Smoke.	
				2. Tobacco Used by Patient	Yes No
PATIENT VISIT (V)  New Patient or 2 -Routine Visit	TYPE O	SCREEN (√)	TOTAL FEES	Counseled About/Referred For Tobacco Use Prevention/ Cessation.	Yes No No
SERVICE LOCATION: Name, Address, Telephone Number (Flease Include Area Code)	HEALTH PLAN CODE/PR		PLACE OF SERVICE		Referred to WIC
NPI# 999999999				NOTE: WIC requires Ht., Wt. and Hem PARTIAL SCREEN 2 SCREENING	oglobin/Hematocrit PROCEDURE RECHECK
Health Net				ACCOMPANIES PRIOR PM 160 DATED PATIENT COUNTY AID IDENTIFICATION	NUMBER
PO BOX 419071	***			PATIENT COUNTY AID IDENTIFICATION ELIGIBILITY	
Rancho Cordova, CA 957	/41				
RENDERING PROVIDER (PRINT NAME):				STATE OF CALIFORNIA-CHILD HEALTH AND DIS	ABILITY PREVENTION PROGRAM

Submit the PM 160 INF form to Health Net's Encounter Department by the  $10^{th}$  day of each month for the previous month's Child Health and Disability Prevention (CHDP) services unless your participating physician group (PPG) instructs otherwise.

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:

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 the Health Net provider website at 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 Health Net's Encounter Department for electronic submission at ENC\_Team@healthnet.com.

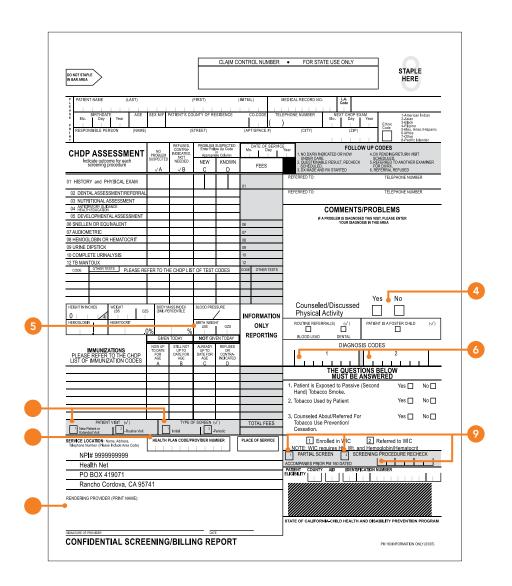
The PM 160 INF form will be rejected if the following three fields are not complete. Providers must:

- 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.

14-081 (continued)



- 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: Kern – 360, Los Angeles – 352, Riverside – 355, Sacramento – 150, San Bernardino – 356, San Diego – 068, San Joaquin – 354, Stanislaus – 361, Tulare – 353
- 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.