

# How to fill out the green PM 160 form for Blood Lead Testing: Fee-for-Service CHDP Providers

Date of Service can match the Health Assessment date, however, the Health Assessment must be submitted on a separate PM 160 form!

CLAIM CONTROL NUMBER • FOR STATE USE ONLY



DO NOT STAPLE IN BAR AREA

PATIENT NAME (LAST) (FIRST) (INITIAL) MEDICAL RECORD NO. LA Code 94 XXXXXXXX J

BIRTHDATE (Mo. Day Year) AGE SEX M/F PATIENT'S CO. 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	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	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

Fill in "15" under CODE and type "Blood Lead" to the right under OTHER TESTS.

01					
06					
07					
08					
09					
10					
12					
CODE	OTHER TESTS	PLEASE REFER TO THE CHDP LIST OF TEST CODES		CODE	OTHER TESTS

REFERRED TO: TELEPHONE NUMBER

REFERRED TO: TELEPHONE NUMBER

**COMMENTS/PROBLEMS**

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

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

HEMOGLOBIN HEMATOOCRIT

BIRTH WEIGHT LBS OZS

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

**IMMUNIZATIONS** PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

ROUTINE REFERRAL(S) (✓) PATIENT IS A FOSTER CHILD (✓)

BLOOD LEAD DENTAL

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

Enter your NPI# here

Enter "81"

Check this box

PATIENT VISIT (✓) TYPE OF SCREEN (✓) TOTAL FEES

1 Initial 2 Periodic

PROVIDER NUMBER PLACE OF SERVICE

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

1  If covered by Medi-Cal, or pre-enrolled in Medi-Cal 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.*

SIGNATURE OF PROVIDER DATE

**CONFIDENTIAL SCREENING/BILLING REPORT**

STATE OF CALIFORNIA-CHILD HEALTH AND DEVELOPMENT PREVENTION PROGRAM

Med P.O. Sac 95851-1300

PM 160 (3/07)

**Note: Do NOT claim any other health assessment services on this form. This form is being submitted for blood lead testing only. If any other health assessment services are put on the form you will NOT be reimbursed!**

This date **MUST** differ from the date of service. It should be the "Christmas" date.