

<b>PATIENT SERVICES SUPPLEMENTAL REPORTING FORM</b>				HID/LOC/SITE:	
PLACE OF SERVICE- If Not Onsite: (J) Inpatient Hospital (K) Outpatient Hospital (L) Physician's Office (M) Patient's Home (O) Other (T) Treatment Center (U) Nursing Home (V) Detention Center (W) Workplace (X) Homeless Shelter				CONTACT DATE:	
PATIENT ID#:		MDCD: (Y) (N) (A) (B) (C) (M) (K)(E)		RACE: check one or more	
PATIENT NAME: Last: First: MI:		E BEG DT: EST. BCCTP TREATMENT END DT:		( W ) White ( B ) Black or African American ( N ) American Indian or Alaska Native ( A ) Asian ( H ) Native Hawaiian or Other Pacific Islander	
HOME PHONE #:		MEDICAID#: M/A PART#:		His/Lat(Hispanic or Latino) ( Y ) Yes or ( N ) No	
NAME OF PARENT/CARETAKER: Last: First: MI:		MEMBER#: AUTH REF: PRIMARY HEALTH PROV.:		SEX: (M) (F) BIRTH DATE:	
		MEDICARE: (Y) (N) MEDICARE#:		MEDICAL RECORD#:	
		KTAP: (Y) (N) FOODSTAMPS: (Y) (N)		HANDS Family ID#:	
				HANDS Family Level:	

<input checked="" type="checkbox"/> OTHER THAN WIC NUTRITION EDUCATION (805)
36 Nutrition Education Class (Other than WIC)

<input checked="" type="checkbox"/> CANCER (When Provider Bills Medicaid or OTP)(813)	
CODE	PROCEDURE/LAB
56	Screening Mammogram
57	Diagnostic Mammogram
58	Pap Smear
87621	HPV test
76645	Breast Ultrasound

<input checked="" type="checkbox"/> MEDICAID TREATMENT FUNDS (813)	
213	Pre-cancerous <b>Breast</b> Conditions
214	Cancerous <b>Breast</b> Conditions
215	Pre-cancerous <b>Cervical</b> Conditions
216	Cancerous <b>Cervical</b> Conditions

<input checked="" type="checkbox"/> DELIVERY (803)	
71	Vaginal Delivery
72	C-Section Delivery
73	Miscarriage

<input checked="" type="checkbox"/> PRENATAL CLASS (803)	
7301	Prenatal Class/Childbirth Class

<input checked="" type="checkbox"/> DENTAL (712)	
D0140	Examination by Dentist
D1211	Dentist follow-up
D1351	Dental Sealant <i>report referral</i> Units

<input checked="" type="checkbox"/> DENTAL (762) Special Project	
D1206	Fluoride Varnish

<input checked="" type="checkbox"/> LEAD TESTS (When Provider Bills Medicaid or OTP) (800, 803 or 810)	
L01	Lead Test Pediatric
L02	Lead Test Maternity
L03	Lead Test Adult Health (Age: 16 yrs or Older)

<input checked="" type="checkbox"/> HANDS SERVICES BILLING (853)			
Medicaid & Tobacco Funded			
T1023	Assessment		
S9444	Home Visit (Paraprofessional)		
S9445	Home Visit (Professional)		
HANDS Referral Codes: (list two-digit number in "referral/specimen codes" block below)			
75 Substance Abuse	79 Physician	83 Education	87 Health Dept
76 Mental Health	80 Domestic Violence	84 Transportation	88 Smoking Cessation
77 Basic Needs	81 Other	85 Child Care	89 Oral Health
78 First Steps	82 N/A	86 Employment	

<input checked="" type="checkbox"/> FLUORIDE (No Face-to-Face) (800)	
S0001	Fluoride Drops – 1 <sup>st</sup> Dose
S0002	Fluoride Drops Refill
S0003	Fluoride Tablets – 1 <sup>st</sup> Dose
S0004	Fluoride Tablets Refill
S0009	Fluoride Water Test
<b>Type of Specimen:</b>	
31- Well Water	
Well Depth: <input type="checkbox"/> 0-50 <input type="checkbox"/> 51-100 <input type="checkbox"/> 101-150	
<input type="checkbox"/> 151-500 <input type="checkbox"/> >500 <input type="checkbox"/> Unknown	
32- Cistern Water	
33- City Water	
34- Bottled Water	
37- Other	

<input checked="" type="checkbox"/> MOMMY AND ME CODES	
99510	Prenatal Nursing Visit
99501	Postpartum Nursing Visit
98966	Prenatal Phone Call
98967	Postpartum Phone Call

PROVIDER	RESULT/ REFERRAL/ SPECIMEN CODES:

