PATIENT SERVICES SUPPLEMENTAL REPORTING FORM

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

HID/LOC/SITE:

CONTACT DATE:

PATIENT ID#:

PATIENT NAME:
Last: First: MI:

HOME PHONE #:

NAME OF PARENT/CARETAKER:
Last: First: MI:

MDCD: (Y) (N) (A) (B) (C) (M) (K)(E)
E BEG DT:
EST. BCCTP TREATMENT
END DT:

MEDICAID#:
M/A PART#:
MEMBER#:
AUTH REF:
PRIMARY HEALTH PROV:

MEDICARE: (Y) (N)
MEDICARE#:

KTAP: (Y) (N)
FOODSTAMPS: (Y) (N)

RACE: check one or more
(W) White
(B) Black or African American
(N) American Indian or Alaska Native
(A) Asian
(H) Native Hawaiian or Other Pacific Islander

His/Lat(Hispanic or Latino) (Y) Yes or (N) No

SEX: (M) (F) **BIRTH DATE**:

MEDICAL RECORD#:

√	**OTHER THAN WIC NUTRITION EDUCATION** (805)	
	36	Nutrition Education Class (Other than WIC)

√	**CANCER** (When Provider Bills Medicaid or OTP)(813)	
	CODE	**PROCEDURE/LAB**
	56	Screening Mammogram
	57	Diagnostic Mammogram
	58	Pap Smear
	87624	HPV test
	76641	Breast Ultrasound – Unilateral – Complete
	76642	Breast Ultrasound – Unilateral – Limited

√	**MEDICAID TREATMENT FUNDS** (813)	
	213	Pre-cancerous **Breast** Conditions
	214	Cancerous **Breast** Conditions
	215	Pre-cancerous **Cervical** Conditions
	216	Cancerous **Cervical** Conditions

√	**DELIVERY** (803)	
	71	Vaginal Delivery
	72	C-Section Delivery
	73	Miscarriage

√	**PRENATAL CLASS** (803)	
	7301	Prenatal Class/Childbirth Class

√	**DENTAL** (712)		
	D0140	Examination by Dentist	
	D1211	Dentist follow-up	
	D1351	Dental Sealant *report referral*	Units

√	**DENTAL** (762) Special Project	
	D1206	Fluoride Varnish

√	**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)

√	**FLUORIDE** (No Face-to-Face) (800)	
	S0001	Fluoride Drops – 1st Dose
	S0002	Fluoride Drops Refill
	S0003	Fluoride Tablets – 1st Dose
	S0004	Fluoride Tablets Refill
	S0009	Fluoride Water Test

Type of Specimen:

	31- Well Water Well Depth: ☐ 0-50 ☐ 51-100 ☐ 101-150 ☐ 151-500 ☐ >500 ☐Unknown
	32- Cistern Water
	33- City Water
	34- Bottled Water
	37- Other

√	**HUMANA VITALITY**	
		HUMANA Vitality

PROVIDER	**RESULT/ REFERRAL/ SPECIMEN CODES:**

√	**LHD DISCRETIONARY Codes 900 through 999**	