Be sure to fill out all appropriate information completely and legibly.
Be sure to write between the lines.
(Do not write in the margins)

Immunization Only

DO NOT STAPLE IN BAR AREA

OL NUMBER • FOR STATE USE ONLY

STAPLE HERE

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

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

REFERRED TO: | TELEPHONE NUMBER

COMMENTS/PROBLEMS

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

CODE	OTHER TESTS	CODE	OTHER TESTS

PLEASE REFER TO THE CHDP LIST OF TEST CODES

For Partial and Immunization Only claims:
Only indicate test(s), other test(s) done on date of service or Immunization(s) given on date of service.

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

HEMOGLOBIN | HEMATOCRIT .0% | BIRTH WEIGHT LBS OZS | %

INFORMATION ONLY REPORTING

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

DIAGNOSIS CODES 1 2

IMMUNIZATIONS
PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

	GIVEN TODAY: NOW UP TO DATE FOR AGE A	GIVEN TODAY: STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	NOT GIVEN TODAY: REFUSED OR CONTRA-INDICATED D	

PATIENT VISIT (√): 1 -New Patient or Extended Visit; 2 -Routine Visit
TYPE OF SCREEN (√): 1 Initial; 2 -Periodic
TOTAL FEES

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 ☐

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)

HEALTH PLAN CODE / PROVIDER NUMBER

PLACE OF SERVICE

Enter **only** the NPI Number here

Enter appropriate POS code here. See back of claim

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 ... OGRAM

Mail Claim To:
CalOptima PPS Unit
P.O. Box 11037
Orange, CA 92856

CONFIDENTIAL SCREENING/BILLING REPORT

(03/07)

PM 160 Information Only BILLING TIPS
For Immunizations Only Claims

All preventive service visits for CalOptima members under age 21 are eligible for additional funding when submitted on a PM 160 Information Only form (PM160 F). Please fill out each PM 160 INF completely, using the guidelines below. For more specific information, refer to the CalOptima Pediatric Preventive Service Provider Resource Manual (Claims Section Part II & III). To receive a manual, additional information, or forms, please call the CalOptima Provider Liaison at (714) 246-8600.

Always Check Member Eligibility To check member eligibility and health plan enrollment:

- ✓ Automated Eligibility Verification System (AEVS) at 1(800)456-2387
- ✓ Point-Of-Service (POS) Device (800) 427-1295
- ✓ Eligibility System-DHS Web site: www.medi-cal.ca.gov
- ✓ CalOptima's Provider Online Tool: www.caloptima.org
- ✓ Interactive Voice Response (IVR) at (800) 463-0935 or (714) 246-8640

➔ Required Information Needed In Completing IMMUNIZATION SECTION Claims

- Patient name – First and last
- Birthdate
- Age
- Sex
- Responsible Person – Name and complete address
- Ethnic code
- Diagnosis Code
- Date of service
- Provider name and address
- Provider number
- Member identification number
- Provider signature (signature on file or signature stamp is not acceptable)
- Date signed

Billing Tips In Completing Immunization Section Claim

- Must enter the immunization code and description if immunizations were given.
- Columns "A" and "B" – if marked, must have a fee.
- Columns "C" and "D" – if marked, may not have a fee.
- Check the patient age with the Immunization code used.
- The Immunization Codes are:

33	MMR, VFC	34	Measles	36	Rubella
38	Hib, VFC	39	Polio: Inactivated Polio Vaccine (IPV)	40	Hepatitis B, VFC (Low Dosage)
41 + 57	HBIG HBIG Fee Balance	42	Hepatitis B, VFC (High Dosage)	45	DTaP
46	Varicella, VFC	48	MMR, Non-VFC	51	Hepatitis B, Non-VFC
52	Varicella, Non-VFC	53	Influenza, VFC	54	Influenza, Non-VFC
55	Pneumococcal	56	Hepatitis B/Hib, VFC	58	Td-Adult
59	DT-Pediatric	60	Td-Adult	63	Hib, Non-VFC
64	Polio Inactivated	65	Hepatitis A	66	Hepatitis A
67	Prevnar	68	Pediarix	69	MCV4 , VFC
70 + 73	MCV4, Purchased	71	FluMist	72	Tdap
74	MMRV, VFC	75	Rotavirus	76	Human Papillomavirus
77 + 78	Human Papillomavirus	79	Tdap	80	Influenza, Inactivated Preservative Free

Where to Submit Claims	Claims Correspondence	Claims Inquiry
All pediatric preventive services claims must be submitted for payment to CalOptima. Send Copy 1 (white) and Copy 2 (yellow) of the completed PM160 INF to:	Submit all correspondence regarding claims, tracer claims, and provider disputes for denied claims to:	For claims status inquiry or any questions regarding submission of PM 160 INF claims, contact:
CalOptima Direct PPS Claims UNIT P.O. BOX 11037 Orange, Ca. 92856	CalOptima Direct PPS Claims UNIT P.O. BOX 11037 Orange, CA 92856	CalOptima PPS UNIT Monday through Friday 8:00 a.m. to 4:00 p.m. (714) 246-8885