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

Partial Assessment

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	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column: KNOWN D	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

DATE OF SERVICE Mo. Day Year

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	PLEASE REFER TO THE CHDP LIST OF TEST CODES	CODE	OTHER TESTS

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

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 ☐

PATIENT VISIT (√): 1 -New Patient or Extended Visit; 2 -Routine Visit

TYPE OF SCREEN (√): 1 Initial; 2 -Periodic

TOTAL FEES

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)

CALOPTIMA A Public Healthcare Agency PM 160 Information Only BILLING TIPS for PARTIAL ASSESSMENT 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 on line at www.caloptima.org. To receive additional information please call the CalOptima Provider Resource line at (714) 246-8600.

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 PARTIAL ASSESSMENT Claims

- Patient name – First and last
- Birthdate
- Age
- Sex
- Responsible Person – Name and complete address
- Ethnic code
- Date of service
- Diagnosis Code
- Provider name and address
- Provider number
- Provider signature (signature on file or signature stamp is not acceptable)
- Date signed
- Member identification number/Country Code/Aid Code
- Prior PM 160 Date

Billing Tips In Completing Partial Assessment Claim

- A Partial Assessment Claim needs only to be marked for the test and/or immunizations that are given.
- Assessment line 6-12 and/or Test procedures 13-26 would be marked. The test given is all that needs to be marked. Test must have code number and name of the test.
- Column "A" – if marked, should have a fee unless appropriate explanation given in comments (example: sent to lab, observation).
- Column "B" – if marked, should not have a fee. The exception is line 12 (TB Mantoux). This can have a fee if in comments it is explained that patient did not return for follow up.
- Columns "C" and "D" – if marked, must be marked with a follow up code (listed on claim, numbers are 1 – 6) and should have a fee, unless appropriate explanation given in comments
- Column "A" may not be marked along with Columns "C" or "D" for the same line.
- Lines 9 and 10 may not be charged for at the same time.
- Immunization – any immunizations performed would be marked. The immunization given is all that needs to be marked. 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.
- When checking the test or immunization given, use the criteria listed above for each column.

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