

9. **Refer Provider No. – Complete this item only if the recipient is linked to another KIDMED provider.** Enter the CommunityCARE PCP's, or the KIDMED provider's, 7-digit Medicaid provider number.
10. **Medicaid No.** - Enter the recipient's 13-digit Medicaid number as verified through the REVS, MEVS, or e-MEVS eligibility systems. This should also be the 13-digit Medicaid number that appears on the RS-0-07 for that month.
11. **Patient Last Name** - Enter the first 17 letters of the recipient's last name, starting at the left of the block, as verified through the REVS, MEVS, or e-MEVS eligibility systems. If the name has less than 17 letters, leave the remaining spaces blank.
12. **Patient First Name** - Enter up to 12 letters of the recipient's first name, starting at the left of the block, as verified through the REVS, MEVS, or e-MEVS eligibility systems. If the name has less than 12 letters, leave the remaining spaces blank.
13. **Date of Birth** - Enter the six-digit date of birth for the recipient, using the MMDDYY format so that all spaces are filled. The recipient must be under age 21 on the date of the screening. Do not leave any of the spaces blank.
14. **Sex** - This item is optional. Enter "M" for male or "F" for female.
15. **Race** - This item is optional. Enter one of the following codes:

Unknown	0	Hispanic or Latino	5
White	1	Native Hawaiian/ Pacific Islander	6
Black or African American	2	Hispanic/Latino and one or more	7
American Indian or Alaskan Native	3	More than one race (Hispanic or	
Asian	4	Latino not indicated)	8
16. **Medical Record No.** - This item is optional. It may be used to cross-reference a patient's medical record number. Enter up to 18 alphabetical and/or numerical characters that have been assigned as the patient's medical record number.
17. **Patient Address** - This item is optional. Enter the recipient's street address or P.O. Box number, starting at the left of the block. Leave any unused spaces blank.
18. **City** - This item is optional. Enter up to nine letters of the city in which the recipient lives, starting at the left of the block. Leave any unused spaces blank.
19. **State** - This item is optional. Enter the commonly accepted postal abbreviation for the state ("LA" for Louisiana).
20. **Zip Code**- This item is optional. Enter the zip code for the recipient's address.
21. **Patient Home Phone** – Complete this item if the recipient has a home phone number or a contact phone number. Enter the three-digit area code and seven-digit home or contact phone number.
22. **Patient Work Phone** – Complete this item if the recipient has a work phone number. Enter the three-digit area code and seven-digit work phone number.
23. **Parent/Guardian Last Name** - This item must be completed for all recipients living with a parent or guardian. A foster parent or adoptive parent is considered a guardian. Enter up to 17 letters of the parent or guardian's last name, starting at the left of the block. Leave any unused spaces blank. If the recipient is not living with a parent or guardian, leave this item blank and skip to item 25.

- 24. Parent/Guardian First Name** – Complete only if item 23 is completed. Enter up to 12 letters of the parent or guardian's first name, starting at the left of the block. Leave any unused spaces blank.

The next part of the claim form documents what type of provider performed the screening. It also documents the screening fee. In addition, it records information about future screenings scheduled.

Providers may bill for four types of screenings:

- **Medical Screening Nurse (99381-99385 and 99391-99395)** This is a medical screening where a registered nurse or physician assistant conducted the **complete unclothed physical exam** and other required age-appropriate medical screening components, including age-appropriate immunizations.

REMINDER: The above codes **MUST BE** billed with **modifier TD**, indicating that a nurse performed the screening.

- **Medical Screening Physician (99381-99385 and 99391-99395)** - This is a medical screening where a licensed physician conducted the **complete unclothed physical exam** and other required age appropriate medical screening components, including age-appropriate immunizations.

☞ Providers must enter one or the other for a single medical screening, but not both. If both a physician and a registered nurse conducted the screening, **the individual performing the physical exam or assessment should be entered.**

- **Vision (99173-EP)** - This is an objective vision screening conducted by a licensed physician, physician assistant, registered nurse, licensed optometrist, or trained office staff under the supervision of one of the above listed licensed professionals. **No claim will be paid on a child under age four.**
- **Hearing (92551)**- This is an objective hearing screening conducted by a licensed physician, physician assistant, registered nurse, licensed and ASHA-certified audiologist, licensed and ASHA-certified speech pathologist, or trained office staff under the supervision of one of the above listed licensed professionals. **No claim will be paid on a child under age four.**

A vision and/or hearing screening will be approved only if there is an age appropriate medical screening listed.

- * **Only Rural Health Clinics and Federally Qualified Health Centers should complete the block marked “Encounter”. ALL other KIDMED providers should leave blank.**

Providers may bill for appropriately performed medical, objective vision, and/or objective hearing screenings on the same screening claim form in any combination.

25. **Date of Screening** - For **each** applicable line, enter the date of the screening. For proper reimbursement, providers must date **each** screening type for which they are billing.
26. **Billed Charge** - For **each** line completed in item 25, enter the appropriate charge for services rendered, using four digits for dollars and cents. For example, \$51.00 would be entered as "5100".
27. **Next Screening Appointment Date** - If a future screening appointment has been scheduled, enter the six-digit appointment date for each applicable line. If no future appointments have been made at the time the claim form is completed, leave blank and skip to item 29.
28. **Time** - If a future screening appointment has been scheduled, enter the appointment time.
29. **Immunization Status** - This item is required and must be completed for **medical screenings only**. Providers must certify whether the recipient's immunizations are complete and current for his or her age. Check "Yes" if immunizations are complete and current for this recipient. Check "No" if they are not. If "Yes" is indicated, skip to item 31.
30. **Reason** - If providers indicate in item 29 that immunizations are not current and complete, they must check the appropriate box explaining why. Check "A" in the case of medical contraindication. Check "B" if the parents or guardians refuse to permit the immunization. Check "C" if immunizations are off schedule. For example, check "C" if the recipient received an immunization at this visit but is still due one for his or her age. Do not check "C" if immunizations are off schedule and immunizations were not given.
31. **Presence or absence of suspected conditions** - This item is required and relates to screening findings. If no suspected conditions are found, check "no" and skip to item 36. If one or more suspected conditions are found, check "yes" and proceed to item 32.
32. **Nature of suspected conditions and referral strategy** - This item documents the general types of suspected conditions identified during the screening and whether or not a referral was made in-house (includes self-referrals) or offsite. Complete it by checking the appropriate boxes. For example, if a suspected medical condition was found for which the recipient is already under care by any provider, check the far left box on the first line. If a suspected nutritional condition is found and has been self-referred, check the far right column on the fifth line (E). If a suspected psychological/social condition is found and an outside referral is made, check the middle column on the eighth line (H). Be sure to enter information about all suspected conditions found. Do not make any entries on lines J through L.



Note that each of these items may require that up to eight different kinds of information are entered in the spaces

marked A, B, C, D, E, F, H, and I.

- 33-35. Referrals for Suspected Conditions** - Providers must complete at least one of these items if any suspected conditions are listed in item 32 as being referred in-house or offsite. The number of items completed will depend on how many conditions were found in the screening and on the referrals made. If more than four suspected conditions are found, providers must fill out at least items 33 and 34. If more than eight suspected conditions are found, providers must fill out items 33 through 35. Also, one item must be completed for each referral made. If there are more referrals than blocks 33-35 will accommodate, such referrals should be documented in the recipient's chart and would not be listed on the claim form.
- 33A. Suspected Condition** - Referring back to item 32, enter in item 33A up to four letters (A through I), identifying the type of condition(s) identified. Remember, the referral may cover up to four conditions, but only one referral provider. Start at the left of the block, and leave any unused spaces blank. **DO NOT enter an ICD-9 diagnosis code or diagnosis abbreviation (e.g., "URI") here—that information should be entered in 33E.**
- 33B. Referral Assist Needed** - Check "no," as this block is no longer used to obtain referral assistance. If assistance is needed from the Louisiana KIDMED office on finding a referral resource, contact ACS at (877) 455-9955.
- 33C. Appointment Date** - If the recipient is referred either in-house or offsite, enter the date of the appointment. The appointment date should be estimated if it is not known at the time the claim form is completed.
- 33D. Appointment Time** - If the recipient is referred either in-house or offsite, enter the time of the appointment. The appointment time should be estimated if it is not known at the time the claim form is completed.
- 33E. Reason for Referral** - Enter the reason for the referral, using up to 40 letters and/or the ICD-9 diagnostic codes. In addition, if referral assistance is needed because the referred-to provider requires direct contact with the recipient, indicate so here.
- 33F. Referred To** - If an in-house or offsite referral is made, enter up to 20 letters of the name of the specific provider to whom the recipient was referred, starting with the last name first. Be as specific as possible. For example, if the recipient was referred to a large facility, give the name and department onsite. If self-referred, enter "self" for this item. Skip to item 36 if there is no other referral information to report.
- 33G. (Blank)** - Do not enter any data here. This item is reserved for future use by KIDMED.
- 33H. Phone No** - If an in-house or offsite referral has been made, enter the area code and seven-digit phone number of the referred-to provider. If a self-referral has been made, leave this item blank.
- 33I. Transportation Assistance Needed** - Check "no," as this block is no longer used to obtain transportation assistance. The recipient (or the recipient's parent) should

contact the Medical Dispatch Office in his region. These telephone numbers are listed in the Medicaid Services Chart.

34 A-I Complete for additional Suspected Condition if applicable.

35 A-I Complete for additional Suspected Condition if applicable.

36. Providers must read and sign the certification statement at the bottom of the screening claim form in order to be paid. Providers may use a signature stamp if it is initialed by the individual completing the form. If a claim form is received without a signature on it the claim form will not be processed and will be returned to the billing provider. A signature certifies that all components of the screening have been provided.

KM-3 claim forms should be mailed to:

**Molina
P.O. Box 14849
Baton Rouge, LA 70821**