MAIL TO:
MolinaKIDMED
P.O. BOX 14849
BATON ROUGE, LA 70898-4849
(800) 473-2783
924-5040 (IN BATON ROUGE)

KIDMED
MEDICAID OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL, VISION AND HEARING SCREENING SERVICES

1. ☐ ORIGINAL ☐ ADJUSTMENT ☐ VOID

2. REASON | 3. ADJUSTMENT ICN

PRINT OR TYPE ONLY - USE BLACK INK

ENCOUNTER

4. BILLING PROVIDER NO.	5. BILLING PROVIDER NAME	6. SITE NO.	7. ATTEND PROVIDER NO.	8. ATTEND PROVIDER NAME	9. REFER PROVIDER NO

10. MEDICAID NO.	11. PATIENT LAST NAME	12. PATIENT FIRST NAME	13. DATE OF BIRTH	14. SEX	15. RACE

16. MEDICAL RECORD NO.	17. PATIENT ADDRESS	18. CITY	19. ST	20. ZIP CODE

21. PATIENT HOME PHONE	22. PATIENT WORK PHONE	23. PARENT/GUARDIAN LAST NAME	24. FIRST NAME
( ) -	( ) -		

SCREENINGS TYPE	PROC.	MOD.	25. DATE OF SCREENING MONTH/DAY/YEAR	26. BILLED CHARGE	27. NEXT SCREENING APPOINTMENT DATE MONTH/DAY/YEAR	28. TIME HR:MIN
MEDICAL SCREENING NURSE						
MEDICAL SCREENING PHYSICIAN						
VISION						
HEARING						
ENCOUNTER (RHC/FQHC)						
TOTAL BILLED AMOUNT						

IMMUNIZATIONS

29. ARE IMMUNIZATIONS COMPLETE AND CURRENT FOR THIS AGE PATIENT?
☐ YES ☐ NO

30. IF IMMUNIZATIONS ARE NOT COMPLETE AND CURRENT AS OF THIS SCREENING, CHECK REASON:
A. ☐ MEDICALLY CONTRAINDICTED
B. ☐ PARENTAL REFUSAL
C. ☐ OFF SCHEDULE

SUSPECTED CONDITIONS

31. ARE THERE SUSPECTED CONDITIONS? ☐ YES ☐ NO

IF YES YOU MUST CHECK AT LEAST ONE OF THE BOXES BELOW AND COMPLETE THE NEXT SECTION IF REFERRED OFF-SITE OR IN-HOUSE.

32.

UNDERCARE	REFERRAL OFFSITE	REFERRAL IN-HOUSE	
			A. MEDICAL
			B. VISION
			C. HEARING
			D. DENTAL
			E. NUTRITIONAL
			F. DEVELOPMENTAL
			G. ABUSE/NEGLECT
			H. PSYCHOLOGICAL/SOCIAL
			I. SPEECH/LANGUAGE
			J.
			K.
			L.

REFERRALS FOR SUSPECTED CONDITIONS

33.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? ☐ Yes ☐ No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) - | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

34.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? ☐ Yes ☐ No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) - | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

35.

A. SUSPECTED COND.	B. REFERRAL ASSIST NEEDED? ☐ Yes ☐ No	C. APPOINTMENT DATE (MONTH/DAY/YEAR)	D. TIME (HR:MIN)

E. REASON FOR REFERRAL

F. REFERRED TO | G.

H. PHONE NO. ( ) - | I. TRANSPORTATION ASSISTANCE NEEDED? ☐ YES ☐ NO

I CERTIFY THAT THE SERVICE LISTED HAS BEEN RENDERED BY A QUALIFIED SCREENING PROVIDER, THAT THE CHARGE IS WITHIN THE DEPARTMENTS' PAYMENT RATE FOR KIDMED SCREENING AND THE PAYMENT HAS NOT BEEN RECEIVED. I AGREE TO ADHERE TO THE PUBLISHED REGULATIONS CONCERNING SCREENING AND KIDMED ADMINISTRATIVE PROCEDURES. I HAVE PERFORMED A COMPLETE SCREENING AS STATED IN THE KIDMED PROVIDER MANUAL.

I CERTIFY THAT ANY MEDICAL SCREENINGS LISTED ABOVE INCLUDE THE FOLLOWING MINIMUM SET OF ACTIVITIES:

- A COMPREHENSIVE HEALTH AND DEVELOPMENTAL HISTORY;
- A COMPREHENSIVE UNCLOTHED PHYSICAL EXAM OR ASSESSMENT;
- APPROPRIATE IMMUNIZATIONS ACCORDING TO AGE AND HEALTH HISTORY (UNLESS MEDICALLY CONTRAINDICATED OR PARENT REFUSED AT THE TIME);
- LABORATORY TESTS (INCLUDING APPROPRIATE LEAD BLOOD LEVEL ASSESSMENT); AND
- HEALTH EDUCATION (INCLUDING ANTICIPATORY GUIDANCE).

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE PLUS THE NOTICE ON THE BACK OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITHIN.

36. SIGNATURE OF PROVIDER | 37. DATE

FISCAL AGENT COPY