

# Pennsylvania Children's Checkup (EPSDT) Form Instructions

General Form Completion Guidelines:

- Complete all fields unless indicated otherwise.
- A completed screen requires a procedure code from each service area required for that age. Refer to the *Pennsylvania Children's Checkup (EPSDT) Program Periodicity Schedule and Coding Matrix*.
- Type or print using blue or black ink when completing forms.
- Multi-part forms: Place on hard surface and press firmly to insure all copies are legible. Do not stack forms.
- Single-part forms: Obtain at [www.dpw.state.pa.us/omap](http://www.dpw.state.pa.us/omap). Refer to Provider Information section.

FIELD	FIELD NAME	INSTRUCTION					
1	<b>Recipient Number</b>	Enter the 10-digit recipient number from the client's Medical Assistance ACCESS card.					
2	<b>Recipient Name</b>	PRINT or TYPE CLEARLY the Last Name, First Name, and Middle Initial of the recipient.					
3	<b>Date of Birth</b>	Enter the eight-digit birth date (mmddccyy) of the recipient being screened.					
4	<b>Date of Screen</b>	Enter the eight-digit date (mmddccyy) on which the screen is performed.					
5	<b>Place of Service</b>	Enter the appropriate code to identify where the service was provided. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">01 Office</td> <td style="padding: 2px;">05 Outpatient Hospital</td> </tr> <tr> <td style="padding: 2px;">03 Inpatient Hospital</td> <td style="padding: 2px;">09 Independent Clinic</td> </tr> </table>	01 Office	05 Outpatient Hospital	03 Inpatient Hospital	09 Independent Clinic	
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6	<b>Provider Type</b>	Enter your two-digit Provider Type. The Provider Type can be found on the enrollment notice sent to you by the Department. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">01 Physician</td> </tr> <tr> <td style="padding: 2px;">10 Independent Medical/Surgical Clinics</td> </tr> <tr> <td style="padding: 2px;">11 Outpatient Hospital Clinics and Emergency Rooms</td> </tr> <tr> <td style="padding: 2px;">26 Rural Health Clinics/Federally Qualified Health Centers</td> </tr> <tr> <td style="padding: 2px;">49 Certified Registered Nurse Practitioners</td> </tr> </table>	01 Physician	10 Independent Medical/Surgical Clinics	11 Outpatient Hospital Clinics and Emergency Rooms	26 Rural Health Clinics/Federally Qualified Health Centers	49 Certified Registered Nurse Practitioners
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7	<b>Provider MA ID Number</b>	Enter the seven digits (dropping the initial zero) of your eight-digit Medical Assistance identification number.					
8	<b>Provider Address Code</b>	<b>Required if submitting the form to AHS (Automated Health Systems).</b> Enter the two-digit address code for the office where the service was provided. The address code is on the enrollment notice sent to you by the Department of Public Welfare.					
9	<b>Payee MA ID/Tax ID Number</b>	<b>Must be completed if you are a member of a GROUP PRACTICE.</b> Fee-for-service providers should enter the seven-digit Medical Assistance Provider ID number assigned to the designated payee by the Department of Public Welfare. Managed Care providers should enter the Federal Tax ID in this field. In no case should the MA ID number entered in Field 7 (Provider MA ID Number) be identical to the number entered here.					
10	<b>Payee Address Code</b>	<b>Must be completed if applicable.</b> Enter the two-digit code to identify the payee location. This field is used in fee-for-service to have checks and Remittance Advices sorted and mailed to each billing location or service delivery address.					
11	<b>Patient Account Number</b>	<b>Optional - For Provider Use Only.</b> Enter a patient identifier. This will appear on the fee-for-service Remittance Advice and can be used to help identify your claim.					
12	<b>Procedure Codes</b>	Check the applicable CPT code(s) for all services provided. Refer to the <i>Periodicity Schedule and Coding Matrix</i> for all required components of a completed screen. Use CPT modifier -52 Reduced Services plus CPT code for standard testing method for objective vision/hearing testing, anemia, urinalysis, lead and tuberculin testing not completed due to patient factors. Use CPT modifier -90 Reference Outside Laboratory when laboratory procedures are performed by a party other than the treating or reporting physician. <b>Immunizations:</b> According to ACIP schedule. For children 18 years and younger, immunization codes are collected for administrative purposes to document antigens given. Because the PA Department of Health provides vaccines free of charge to providers through the Vaccines for Children Program (see MA Bulletins 01-00-10, 10-00-03, 11-00-05, 26-00-04), only a vaccine administration fee may be reimbursed.					
13	<b>Diagnosis Codes</b>	Enter all applicable ICD-9CM diagnosis code(s). The general diagnosis code V20.2 (Routine infant or child health check) is included for your convenience. Any additional applicable ICD-9CM codes should be entered. An appropriate diagnosis code should be included for each referral. Immunization V codes are not required.					
14	<b>Number of Referrals</b>	Enter the number of referrals made or needed as a result of the screen. If assistance is needed with the referral, please contact the appropriate Managed Care Organization (MCO) or AHS. The MCO or AHS may require providers to complete a referral form.					
15	<b>Submit Screening Form To</b>	<b>Optional - For Provider Use Only.</b> Check the box for the organization that should receive the screening form					

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TYPEWRITER/PRINTER ALIGNMENT GUIDES

1. Recipient Number		2. Recipient Name - Last, First, MI									
3. Date of Birth (mmddccyy)			4. Date of Screen (mmddccyy)			5. Place of Service		6. Provider Type		7. Provider MA ID Number	
8. Provider Address Code		9. Payee MA ID/Tax ID Number			10. Payee Address Code		11. Patient Account Number - Optional - For Provider Use Only				

12. Procedure Codes

Comprehensive Health History/Physical Exam

<input type="checkbox"/> 99431 Newborn Care	<input type="checkbox"/> 99435 Newborn (same day discharge)
<b>New Patient</b>	<b>Established Patient</b>
<input type="checkbox"/> 99381 Age < 1 yr	<input type="checkbox"/> 99391 Age < 1 yr
<input type="checkbox"/> 99382 Age 1-4 yrs	<input type="checkbox"/> 99392 Age 1-4 yrs
<input type="checkbox"/> 99383 Age 5-11 yrs	<input type="checkbox"/> 99393 Age 5-11 yrs
<input type="checkbox"/> 99384 Age 12-17 yrs	<input type="checkbox"/> 99394 Age 12-17 yrs
<input type="checkbox"/> 99385 Age 18-20 yrs	<input type="checkbox"/> 99395 Age 18-20 yrs
<b>Vision</b>	<b>Dental</b>
<input type="checkbox"/> 99173 Visual Acuity Screen	<input type="checkbox"/> Check here if child is 3 yrs. or older and is currently receiving dental care or is being referred for dental care.
<input type="checkbox"/> -52 Reduced Services Modifier	
<b>Anemia Screening</b>	<b>Hearing</b>
<input type="checkbox"/> 85013 Hematocrit (spun)	<input type="checkbox"/> 92551 Audio Screen
<input type="checkbox"/> 85018 Hemoglobin	<input type="checkbox"/> 92552 Pure tone-air only
<input type="checkbox"/> 85022 Hemogram (automated)	<input type="checkbox"/> -52 Reduced Services Modifier
<input type="checkbox"/> -52 Reduced Services Modifier	<b>Tuberculin Testing</b>
<input type="checkbox"/> -90 Reference Outside Laboratory	<input type="checkbox"/> 86580 Tuberculosis, intradermal
	<input type="checkbox"/> -52 Reduced Services Modifier
<b>Lead Screen</b>	<b>Urinalysis</b>
<input type="checkbox"/> 83655 Lead	<input type="checkbox"/> 81000 Dip stick with microscopy
<input type="checkbox"/> -52 Reduced Services Modifier	<input type="checkbox"/> 81002 Dip stick without microscopy
<input type="checkbox"/> -90 Reference Outside Laboratory	<input type="checkbox"/> 81001 Automated with microscopy
<b>Immunizations *</b>	<input type="checkbox"/> 81003 Automated without microscopy
<input type="checkbox"/> 90744 HepB/peds	<input type="checkbox"/> 90702 DT
<input type="checkbox"/> 90700 DTaP	<input type="checkbox"/> 90645 HbOC
<input type="checkbox"/> 90713 IPV	<input type="checkbox"/> 90646 PRP-D
<input type="checkbox"/> 90669 Pneumo7	<input type="checkbox"/> 90647 PRP-OMP
<input type="checkbox"/> 90716 Varicella	<input type="checkbox"/> 90710 MMRV
<input type="checkbox"/> 90718 Td/adult	<input type="checkbox"/> 90707 MMR
<input type="checkbox"/> 90733 Meningo	<input type="checkbox"/> 90746 HepB/adult
<input type="checkbox"/> 90748 HepB-hib	
	<b>Other Procedures</b>

13. Diagnosis Codes

<input type="checkbox"/>	V 2 0 . 2
<input type="checkbox"/>	.
<input type="checkbox"/>	.
<input type="checkbox"/>	.
<input type="checkbox"/>	.
<input type="checkbox"/>	.

14. Number of Referrals

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15. Submit Screening Form To:

<input type="checkbox"/>	AHS-FCN
<input type="checkbox"/>	AHS-FFS
<input type="checkbox"/>	AHS-LCHP
<input type="checkbox"/>	AmeriChoice
<input type="checkbox"/>	AmeriHealth Mercy
<input type="checkbox"/>	Gateway
<input type="checkbox"/>	Health Partners
<input type="checkbox"/>	Keystone Mercy
<input type="checkbox"/>	MedPLUS+
<input type="checkbox"/>	UPMC/Best
<input type="checkbox"/>	

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