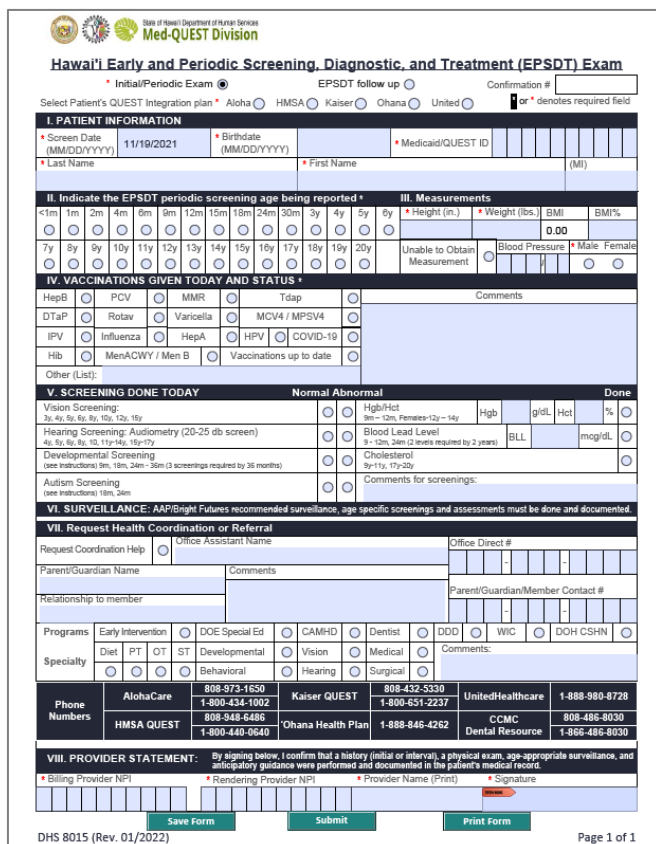


## EPSDT Fillable PDF



**Hawai'i Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Exam**

Initial/Periodic Exam ☒ EPSDT follow up ☐ Confirmation # \_\_\_\_\_

Select Patient's QUEST Integration plan: Aloha ☐ HMSA ☐ Kaiser ☐ Ohana ☐ United ☐ or \* denotes required field

**I. PATIENT INFORMATION**

Screen Date (MM/DD/YYYY) 11/19/2021 Birthdate (MM/DD/YYYY) \_\_\_\_\_ Medicaid/QUEST ID \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ (MI) \_\_\_\_\_

**II. Indicate the EPSDT periodic screening age being reported \***

|                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <1m                   | 1m                    | 2m                    | 4m                    | 6m                    | 12m                   | 15m                   | 18m                   | 24m                   | 30m                   | 3y                    | 4y                    | 5y                    | 6y                    |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

**III. Measurements**

Height (in.) \_\_\_\_\_ Weight (lbs.) \_\_\_\_\_ BMI \_\_\_\_\_ BMI% \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

**IV. VACCINATIONS GIVEN TODAY AND STATUS \***

|                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                         |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-------------------------|
| HepB                  | PCV                   | MMR                   | Tdap                  | DTaP                  | Rotav                 | Variola               | MCV4 / MPSV4          | IPV                   | Influenza             | HepA                  | HPV                   | COVID-19              | Hib                   | MenACWY / Men B       | Vaccinations up to date |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>   |

**V. SCREENING DONE TODAY**

| Normal                                                                                         | Abnormal              | Done                                                        |
|------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------|
| Vision Screening: 3y, 4y, 5y, 6y, 8y, 10y, 12y, 15y                                            | <input type="radio"/> | High/Low: 9m-12m, Females 12y-14y                           |
| Hearing Screening: Audiometry (20-25 db screen)                                                | <input type="radio"/> | Blood Lead Level: 9-12m, 24m (2 levels required by 2 years) |
| Developmental Screening: (see instructions) 18m, 24m, 30m (3 screenings required by 36 months) | <input type="radio"/> | Cholesterol: 9y-11y, 17y-20y                                |
| Autism Screening: (see instructions) 18m, 24m                                                  | <input type="radio"/> | Comments for screenings: _____                              |

**VI. SURVEILLANCE: AAP/Bright Futures recommended surveillance, age specific screenings and assessments must be done and documented.**

**VII. Request Health Coordination or Referral**

Request Coordination Help ☐ Office Assistant Name \_\_\_\_\_ Office Direct # \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Comments \_\_\_\_\_ Parent/Guardian/Member Contact # \_\_\_\_\_

Relationship to member \_\_\_\_\_

Programs: Early Intervention ☐ DOE Special Ed ☐ CAMHD ☐ Dentist ☐ DDD ☐ WIC ☐ DOH CSHN ☐

Specialty: Diet ☐ PT ☐ OT ☐ ST ☐ Developmental ☐ Vision ☐ Medical ☐ Behavioral ☐ Hearing ☐ Surgical ☐

Phone Numbers: AlohaCare 808-973-1650 Kaiser QUEST 808-432-5330 UnitedHealthcare 1-888-980-8728  
HMSA QUEST 1-800-434-1002 1-800-651-2237 CCMC Dental Resource 808-486-8030  
HMSA QUEST 808-948-6486 Ohana Health Plan 1-888-846-4262

**VIII. PROVIDER STATEMENT:** By signing below, I confirm that a history (initial or interval), a physical exam, age-appropriate surveillance, and anticipatory guidance were performed and documented in the patient's medical record.

Billing Provider NPI \_\_\_\_\_ Rendering Provider NPI \_\_\_\_\_ Provider Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_

Save Form Submit Print Form

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### 8015 Fillable PDF

#### Section I: PATIENT INFORMATION

- Visit Date prepopulates. If different, needs to be updated.
- 10-digit Medicaid ID. You **MUST ENTER** all 10-digits. If there are leading zeros (0), you need to enter those.

#### Section II: Indicate the EPSDT periodic screening age being reported

- Screening age prepopulates based on screen date and birthdate entered. If different, manually select the preferred screening age.

#### Section III: Measurements

- Height in inches
- Weight in pounds
- Manually calculate the BMI%
- Select Male or Female

#### Section IV: VACCINATIONS GIVEN TODAY AND STATUS

- Vaccinations – If no selections are made or not up to date, please add reason or plan in comment

#### Section V: SCREENING DONE TODAY

- Screening – If attempted, but unable to complete an expected screening, add reason plan in comment

#### Section VII: Request Health Coordination or Referral

- The health plan will contact your office if selected, so provide the name of the person you want them to talk to and their direct contact #.
- If phone numbers are not available for member contact, provide any known way to contact the member/guardian so that the health plan can reach them and provide requested support.
- Only indicate programs or specialties that are being referred to at this visit. Also indicate if already in the program but completing eligibility exam or paperwork for programs in this visit too.

#### Section VIII: PROVIDER STATEMENT

- Rendering and Billing provider may (occasionally, but rarely) be the same
- NPI - the same as the 1500 claim form
- You can digitally sign or print and sign.  
(NOTE: You will need to login submit EPSDT visit data online using your username and pin).

### 8016 Fillable PDF

- All of the same things on the 8015 + Section II
- Initial Visit Confirmation #
- Initial Visit Date