

Show Me Healthy Women Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) System Manual



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MOHSAIC

Providers are required to manually enter Show Me Healthy Women (SMHW) data in the Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) web application. MOHSAIC is a program management and public health surveillance tool. It is not an electronic health record (EHR) and should not be used to gather any information beyond required data elements used for cardiovascular screening surveillance. Based on data entered, agency grant activity statements are generated within the MOHSAIC application, making MOHSAIC data entry the only way WISEWOMAN service delivery providers can access grant funds.

Data Collected and Reported in MOHSAIC

All SMHW providers must collect and store data on breast and cervical screenings. The program provides a set of paper forms. Information gathered on paper forms represents all data that must be reported via MOHSAIC.

Data must be entered within sixty (60) days of providing cardiovascular services to a SMHW client. If waiting for insurance reimbursement/approval forms, notify the SMHW Regional Program Coordinator (RPC) and document this in the 'Comment' section of the form.

Accessing MOHSAIC

<u>MOHSAIC LOCATION AND SOFTWARE REQUIREMENTS</u> The MOHSAIC application is located on MDHSS Portal at: <u>http://webapp01.dhss.mo.gov/SMHW/Default.aspx</u> or <u>https://webapp02.dhss.mo.gov/SMHW/Default.aspx</u>

Providers do not need to install additional software beyond a web browser. MOHSAIC data entry is a WISEWOMAN contract requirement; therefore, it is important that MOHSAIC users at each provider have access to an MOHSAIC-supported web browser.

Requesting Access to MOHSAIC

To apply for access to MOHSAIC, applicants will need to follow the instructions below requesting access to Show Me Healthy Women.

<u>CREATING AUTOMATED SECURITY ACCESS PROCESSING (A.S.A.P) USER PROFILE</u> **This step is to be completed only once per user.**

If you have an ASAP profile already and you know your login credentials, please skip to Step 2 (submitting the request).

If you are unsure if you have an ASAP profile, follow the following steps to help determine that:

- If you already have an LPHA email account, DHSS health applications and/or DSS prod/mainframe access, you most likely have an ASAP profile.
- If you try to create an ASAP profile and you receive a red message indicating the first and last name are already in use, please contact the ITSD Call Center at 800-347-0887 for assistance. This most likely means you have an ASAP profile and the call center can assist with profile updates, password resets, logging into ASAP, and/or submitting requests.

STEPS TO CREATING AN A.S.A.P USER PROFILE

- Open Internet Browers and enter address
 - http://webapp02.dhss.mo.gov/asap_web/ASAPLogin.aspx
- Click 'Yes' to any security messages

Steps	Screen Print
1. Click the NEW USER option	PROVINCE VARIANCE VARIANCE VARIANCE PROVINCE PR
 Enter your first name, last name and last four digits of your SSN. Enter a Preferred First Name, if desired Click the CREATE USERID button. 	ENTER FIRST NAME, LAST NAME AND LAST FOUR DIGITS OF S.S.N TO CREATE ASAP PROFILE First Name: Last Name: Used As part of your email Address. ex:PreferredFirstName LastN CREATE USERID
3. Make note of your UserID.	*USERID: *Agency: *Agency: Choose the appropriate agency Choose the appropriate agency DHSS Employee or Contractor LPHA (Local Public Health Agency) Others (Schools, Private Providers, etc)
 Choose 'Others (Schools, Private Providers, etc.)' for the Agency. Choose 'DHSS DIVISION OF COMMUNITY HEALTH' for Local Community Officer County. 	*Agency: Others (Schools, Private Providers, etc) *Local Security Officer County: DIVISION OF COMMUNITY AND PUBLIC HEALTH - DCPH *Local Security Officer: SHOW ME HEALTHY WOMEN LSO (MARY NOVINGER)
 5. Choose 'SHOW ME HEALTHY WOMEN LSO – (Sandy Hentges)' for Local Security Officer. 	

6.	Type your work street number; it will provide a drop-down list. Click your address Enter your e-mail address, telephone number, and fax number	ADDRESS INFORMATION Address Search (Type in your address starting with Street Number)
8.	Enter a password Retype your password Enter a challenge question. This should be a question only you know the answer to. Type the response or answer to the challenge question Retype the response or answer to the challenge questions **If ASAP did not prompt you to create a password, your password was automatically set to first initial of first name, first initial of last name, and last four digits of your social security number.**	* Password [Password length between 6-8] * Retype Password
9.	Click the CREATE PROFILE button	CREATE PROFILE
10.	You should see a message about the profile being successfully created. Make note of your User ID	PROFILE SUCCESSFULLY CREATED. Your ASAP User ID has successfully been generated. Your User ID is: USERL Request Access

------ PLEASE CONTINUE TO NEXT PAGE TO REQUEST SMHW ACCESS------

REQUEST SMHW ACCESS

- Open Internet Brower and enter address

http://webapp02.dhss.mo.gov/asap_web/ASAPLogin.aspx

- Click 'Yes' to any security messages

 Type the User ID and Password you created in Step A. Click the SIGN IN button. **If ASAP did not prompt you to create a password, your password was automatically set to first letter of first name, first letter of last name, and last four digits of your social security number.** 	>> ASAPLogin he Missouri Department of Health and Senior Services urity Access Process(A.S.A.P) site. uest new access or change existing access for various silication systems supported by the Department of Health acces. NEW USER? an ASAP user Profile, If you require access to a DHSS rork or applications NEW USER	EXISTING ASAP USERS ENTER USER ID AND PASSWORD TO SIGN IN * ASAP User Id : RACKEN * Password : ••••••• SIGNIN FOROOT FOROOT CHANGE USER USER ID? PASSWORD? PROFILE?
 Choose the 'Completing for Self' option. Click the NEXT button. 	Who are you completing t COMPLETING FOR SEL COMPLETING FOR OTH APPROVE REQUESTS VACATIONS NEXT	t his ASAP request f .F IER EMPLOYEE
 Choose 'HEALTH APPLICATIONS' for Area Type. Choose 'SHOWMEHEALTHYWOMEN' for Health Area Type. Choose 'ADD ACCESS' for Request Type. Choose appropriate role from the Role drop down list. *Hold the Ctrl key to select multiple role(s). As roles are selected, they will become highlighted. (Use the scroll bars to scroll up and down to view the complete list). Choose appropriate role from the Other Role/Report Type dropdown list. Choose SMHWPROVIDER (****For Use By SMHW Provider) ONLY. Optional: Type in any comments 11. Type in the Effective Date 	*Area Type: *Health Area Type: *9 Digit S.S.N: *Request Type: *Role: * Other Role/Report Type: Comments: * Effective Date [MM/DD/YY94]: Do you enter Para for Additional Accurces?	HEALTH APPLICATIONS SHOW ME HEALTHY WOMEN ADD ACCESS ADD ACCESS Use Ctri+click to choose more than one role SMHWFUNDSANDWARRANTSADMINISTRAT(SMHWMDEADMINISTRATOR (SUBMIT FORM: SMHWMEDICAIDELIGIBILITYPROCESSOR (P SMHWPROVIDER (****FOR USE BY SMHW PF SMHWPROVIDER (****FOR USE BY SMHW PF SMHWPROVIDER (****FOR USE BY SMHW PF NONE ✓ O YES INO



If you experience any problems or have questions while using the ASAP system, please notify the DHSS ITSD Call Center using one of the following methods:

Telephone: 573-751-6388 or 1-800-347-0887 Email: Support@health.mo.gov

When an existing MOHSAIC user no longer needs access for WISEWOMAN data entry, an agency must report to WISEWOMAN program staff within 15 days.

Navigating MOHSAIC

LESSON 1: THE CLIENT

MOHSAIC HELPFUL TIPS:

- 1. Use Internet Explorer
- 2. Check Compatibility setting
- 3. Check text size for screens with overlapping words or adjust zoom setting if needed
- 4. Turn off Pop-Up Blockers (MOHSAIC uses pop-up screens for data information)

Steps to Access the MOHSAIC Application and Log onto the SMHW Application

Log-in Process

Open the Internet browser and enter the Web address on the address line: https://webapp01.dhss.mo.gov/SMHW/Default.aspx or

https://webapp02.dhss.mo.gov/SMHW/Default.aspx.

- If this is the first time to login, a password must be established:
 - Use the username and assigned password provided to you by e-mail from SMHW, when approved. User name is usually the first five letters of last name and first name initial. Initial password is first and last name initials and last four digits of SSN.
 - Click on 'Change Password.'
 - If you do not login to MOHSAIC for 30 days, the system will 'lock out.' You must call the ITSD Help Desk at 800-347-0887 to unlock and enter new password.
 - After a password is established, the program will ask to change your password every 30 to 60 days. This can be numbers, letters, or a combination, as desired. Password requires six (6) to eight (8) characters and one numeric value.

Once logged in, your agency name will appear and stay constant throughout the application. Click the 'Login' button to proceed.

Login - Microso	oft Internet Explorer	<u> </u>
File Edit View Favo	rites Tools Help	
3) Back 🔻 🌖 🔻 🛃	🚊 🐔 🔎 Search 🤺 Favorit	es 🚱 🔂 👻 🐨 🕶 🛄 💽 🍊
Address Address //web	papp01.dhss.mo.gov/Login/Logi	n.aspx?ReturnUrl=%2fsmhw%2fDefault.aspx 🗾 🔁 Go 🛛 Link
	EALTH AND SENIOR SER	AUCES 1
Login	EALITIAND SENIOR SER	WICES
Enter Legan Infi	2, Select Agency	
 Check Change Passwo Enter the login inform Click Login to proceed 	ord to change passwords ation 1.	
Login Information		Disclaimer
Username		Notice: You are about to gain access to the MOHSAIC system. By proceeding, you are agreeing to keep confidential all information made
Password	Change Password	available to you through this application. Any unauthorized access, use and/or disclosure of information may result in a loss of access privileges an action for civil damages, an action for criminal charges, and/or disciplinary action including but not limited to suspension or dismissal.
Login Cancel		
Login Cancer		

How to Look up SMHW Medicaid Status in MOHSAIC 1) Sign in to MOHSAIC

2) Click on the *Client* Tab then, click on *View Medicaid Information*:

EPARTMENT OF I	HEALTH AND SENIOR	SERVICES SHO	OW ME HEALTHY MISSOURIANS
CLIENT PROVIDE	RA	IVE	
W FORMS / BILLING	VIEW MEDICAID INFORMATION	VIEW NONTHLY ACTIVITY REPORT	
	WELCO	METO	
	мон	SLIC	

3) Click on Change Client:

	ALTH AND SENIOR SERVIC		TUMNINGOOLIDIANO	
DEPARTMENT OF THE	ALTH AND SENIOR SERVIC	SHOW ME HEA	LIHY MISSOURIANS	
CLIENT PROVIDER	FINANCIAL ADMINISTRATIVE			
SUBNET NEW FORMS / BILLING	VIEW MEDICAID INFORMATION	ONTHE V ACTIVITY REPORT		
Client Name: Client - None	Selected Client DCN:			
ethician ethica				
Change Client				
Client's Medicaid Status				
Client's Medicaid Status Status	St	atus Date		
Client's Medicaid Status Status Medicaid Case Information	st	atus Date		
Client's Medicaid Status Status Medicaid Case Information Case DCN	St	atus Date	Status	
Client's Medicaid Status Status Medicaid Case Information Case DCN Telephone	ri M	atus Date	Status	
Client's Medicaid Status Status Medicaid Case Information Case DCN Telephone Address 1	st n	atus Date	Status	
Client's Medicaid Status Status Medicaid Case Information Case DCN Telephone Address 1 Address 2	st	atus Date	Status	
Client's Medicaid Status Status Medicaid Case Information Case DCN Telephone Address 1 Address 2 City	St	atus Date	Status State	Zlp
Client's Medicaid Status Status Medicaid Case Information Case DCN Telephone Address 1 Address 2 City Worker Name	st M	atus Date	Status State	Zip
Client's Medicaid Status Status Medicaid Case Information Case DCN Telephone Address 1 Address 2 City Worker Name Worker Phone	st n	atus Date	Status	zlp
Client's Medicaid Status Status Medicaid Case Information Case DCN Telephone Address 1 Address 2 City Worker Name Worker Phone Spend Down Amt	St.	atus Date	Status State	Zip
Client's Medicaid Status Status Medicaid Case Information Case DCN Telephone Address 1 Address 2 City Worker Name Worker Phone Spend Down Amt Client's Medicaid Dates	5t	atus Date	Status	Zip
Client's Medicaid Status Status Medicaid Case Information Case DCN Telephone Address 1 Address 2 City Worker Name Worker Name Worker Phone Spend Down Amt Client's Medicaid Dates Begin Date	St n End Date	atus Date Program	Status State Level Of Care	Zip ME Code

4) The Client Search box will open. Type in Last Name, First Name, DOB and Gender & click on Search. You must complete all boxes or it will not search for names.

CLIENT	PROVIDER FINANC	IAL ADMIN	ISTRATIVE	SHOWMEN		ISSOUR	IAINO	
MIT NEW FORMS /	BILLING VIEW NEDD	ALL INFORMATIC		ACTIVITY REPORT				
0	Client Search - Webpag	e Dialog				×	1	
ient Name:	🧀 https://webau#01.dbss	mo.gov/PartyIr	formation /SMHWCTientS	carch.aspx0RandID=0.530898097	14546R5	â		
Medicaid Da	Last Name: Mouse	1		First Name	Minnie			
Managed Ca	DOB: 11/20/19	(1) × M	M/DD/YYYY	Gender	Female V			
Change Data refrest			Search Clear	Close				
liont's Medi			71				-	
tatus			4					
edicaid Cas								
lephone								
dress 1								
ty							MO	zip
orker Name								
orker Phone								
ient's Medi								
egin Date							vel Of Care	
/1/2016							-	

5) Click on the Client's name in blue, the box will display *Please wait...* and then should disappear to display the MOHSAIC screen with MEDICAID coverage information.

Image: State of the system	MM/DD/YYYY Search Cl ssn	ear Close	dID=0,53089809704 First Name: Gender:	Minnie Female V
Image: Metappul.ans.mo.gov/Paroinformation/SMHWClientStatch.aspx:Randu =0.5303900970434663 Last Name: Mouse DOB: 11/20/1971 MM/DD/YYYY Gender: Female OB: 11/20/1971 Mouse, Minnie 000-22-0001 00023999 11/20/1971	MM/DD/YYYY Search Cl Sssn	ear Close	First Name: Gender:	Minnie Female
Last Name: Mouse DOB: 11/20/1971 MM/DD/YYYY Gender: Female Search Clear Close Name SSN DCN Date of Birth Gender Mouse, Minnie 000-22-0001 00023999 11/20/1971 FEMALE 1 Cas	MM/DD/YYYY Search Cl ssn	ear Close	First Name: Gender:	Minnie Female V
Ted DOB: 11/20/1971 MM/DD/YYYY Gender: Female V Search Clear Close Name SSN DCN Date of Birth Gender Mouse, Minnie 000-22-0001 00023999 11/20/1971 FEMALE 1 Cas Medi	MM/DD/YYYY Search Cl SSN	ear Close	Gender:	Female 🗸
Search Clear Close Name SSN DCN Date of Birth Gender Mouse, Minnie 000-22-0001 00023999 11/20/1971 FEMALE 1	Search Cl	ear Close		
Name S5N DCN Date of Birth Gender Mouse, Minnie 000-22-0001 00023999 11/20/1971 FEMALE 1	SSN	I		
Mouse, Minnie 000-22-0001 00023999 11/20/1971 FEMALE 1 <td></td> <td>DCN</td> <td>Date of Birth</td> <td>Gender</td>		DCN	Date of Birth	Gender
I Casi Image: State Sta	000-22-0001	00023999	11/20/1971	FEMALE
Cas me one (I) A edi				
me one (n A edi				
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me one vn A redi				
one vn A redi				
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ledi				
e		000-22-0001	000-22-0001 0002 3999	000-22-0001 00023999

6) You should be able to view the Client's Medicaid coverage information. This info comes directly from DSS and is usually refreshed daily. This MoHealthnet coverage information is also what providers can access in eMOMED.

CLIENT PRO	NUDER PINANCIAL ADMINISTR			
UBMIT NEW FORMS / BILLIN	VS VIEW MEDICATO INFORMATION	VIEW MONTHLY ACTIVITY REPORT		
lient Name: Min	nie Mouse Clie	nt DCN:		
Medicald Data wa	is last refreshed from DSS at: 6/16/	2016 12:00:00 AM		
Managed Care Da	ita was last refreshed from DSS at:	5/16/2016 12:00:00 AM		
Character Chinese				
Data refreshed si	iccessfully from DS5 at:6/16/2016 2	14:55 PM		
Client's Medicaid	Status			
Status	ACTIVE	Status Date		
Medicaid Case Inf	formation			
Case DCN	00023999		Status	
Telephone				
Address 1	PO BOX 152			
Address 2				
City	SMALLVILLE		State MO	Zip 012345
Worker Name				
Worker Phone				
Spend Down Amt	Q			
Client's Medicaid	Dates			
Begin Date	End Date	Program	Level Of Care	ME Code
			т	05
4/1/2016				
4/1/2016 3/1/2010	12/3/2010		т	05

In this example you can see Minnie Mouse has ME Code 05 with a start day of 4/1/16 & no end date. So, as of 4/1/16 her MoHealthnet coverage is active and she is not eligible for SMHW.

What the DHSS SMHW RPC sees on this screen is the same as what the SMHW provider would see in MOHSAIC as well.

How to Edit/Change a Client Name in MOHSAIC

1) Pull up the client in MOHSAIC that needs a name change in the CLIENT-Submit New Forms/Billing Screen.

2) Then, Select View/Edit Client Information

Current Cli	lient: LINDSAY, JENNIFER 27066 VIMPIC DR LEBANON, MO 65536-4995 County: LACLEDE (417) 718-0979
CLIENT	PROVIDER FINANCIAL ADMINISTRATIVE
UBMIT NEW FORMS	IS / BILLING VIEW MEDICAID INFORMATION VIEW MONTHLY ACTIVITY REPORT
how Instruction	ins
Submit Fo	orm
lient Informati	ton – Please verny audress and demographics below and update – needed.
Client Name / SSN LI	INDSAY, JENNIFER ? View/Edit Client Information
Address 27	SSN 123-445-8789 Sex FEMALE
	DOB 3/15/1975 Race WHITE
	DCN 99987626 Ethnicity NON HISPANIC
Zip LE	LEBANON , MO , MO , 65536-4995 Phone 417 - 718 - 0979 No Phone
rovider Inform	nation
	O Regular Billing O Direct Billing
Provider	r Referring V
Provide	Provider
Service Name/Address	.e. V
orm Type/Vers	rsion
T	pe V
ryp	

3) When this Screen (also linked to DSS) comes up, scroll to the bottom and Click EDIT.

CLIENT	PROVID	ER F	INANCIAL	ADMINIST	RATIVE	
UBMIT NEW FOR	MS / BILLING	VIEW MEDI	CAID INFORMATION	VIEW MONTH	ILY ACTIVITY REPORT	
View Basi	c Demogra	aphic Info	rmation	Regui	red fields are denot	ed by *
EDIT DELETE	HAME LD. 1476343057	NAME TYPE PRINCIPAL	PRIMARY PREFL YES	A FERST NAME JENNIFER	HELDLEWARE LAS	BENAME SUFFLAG DSAY
Add Party I	Name					
SEX.*			DATE OF BIRTH*		DATE OF DEATH	
FEMALE	~		3/15/1975		-	
DEPARTMENT 98967626	CLIENT NUME	IER. (DCN)				
PRIMARY LAN	GUAGE *					
SPECIAL ASS	ISTANCE	1.1	Reason		vpe.	

4) Then Click on ADD PARTY NAME (DO NOT try to EDIT/DELETE a Client Name)

Edit Basic	Demogra	phic Infor	mation	ON Required fields are denoted by *					
	NAME ID	NAME TYPE	PRIMARY PREFIX	FIRST NAME	MIDDLE NAME	LAST NAME SUFFIX			
EDIT DELETE	1476343057	PRINCIPAL	YES	JENNIFER		LINDSAY			
Add Party N	lame								
SEX			DATE OF BIRTH*		DATE OF DE	ATH			
FEMALE	~		3/15/1075						

5) In the "Client Information" pop up box that appears, select Name Type-PRINCIPAL, enter in the Correct Last Name, First Name, and Middle Name (if applicable), then hit- **Apply Changes**.

Edit Basic Demogra	phic Infor	mation	Required f	ields are denoted by *	
NAME ID	NAME TYPE	PRIMARY PREFIX	FIRST NAME MI	DDLE NAME LAST NAME S	UFFIX
EDIT DELETE 1476343057	PRINCIPAL	YES	JENNIFER	LINDSAY	
Add Party Name SEX* FEMALE V		DATE OF BIRTH [#] 3/15/1975		DATE OF DEATH	
DEPARTMENT CLIENT NUME 99987626	BER (DCN)				
PRIMARY LANGUAGE *	(Client In		Primary: YES	~
SECONDARY LANGUAGE	(Prefix: Last Name:		First Name: JENN	IFER
Reads Primary Language	L	Suffix:			
Writes Primary Language	L	1/IF	Apply C	hanges Cancel	
Race *					

6) You should now see the new correct name appear at the top of the Screen as Name Type "**Principal**" along with all previous names used in the system. Then Scroll to the bottom and Click "**SAVE**".

	NAME ID	NAME INPE	DRUBORY PREFLY	FIRST NAME MIDDLE NAME	LAST NAME SUFFL
EDIT DELETE	117196522165	PRINCIPAL	YES	JENNIFER	SMITH
EDIT DELETE	117077840530	A-K-A.	NO.	JENNIFER.	LINDSAY
	_			1Pc.	
	1	Add		100 million (100 m	
	4	Add			

7) You should now see the Correct Last Name in the submit screen Box. This Name will appear on all Future forms entered but will NOT change the name to forms previously entered with a different Name.

SUBMIT NEW FO	RMS	/ BILLING INFORMATION INFORMAT
Show Instruct	tions	5
Submit	For	rm
Client Inform	natio	n Please verify address and demographics below and update as needed.
Client Name / SSN		SMITH, JENNIFER ? View/Edit Client Information
Address	270	66 OLYMPIC DR SSN 123-445-6789 Sex FEMALE DOB 3/15/1975 Race WHITE DCN 98987626 Ethnicity NON HISPANIC
City, State Zip	LEE	3ANON ▼, MO ▼ 65536-4695 Phone 417 - 532 - 5797 □ No Phone
Provider Info	erma	dion
		O Regular Billing O Direct Billing
Prov	ider	Referring Provider
Sen Name/Add	vice ress	✓
Form Type/V	/ersi	on
1	Туре	
Ver	rsion	Create Form Close

8) NOTE: Any forms already entered and viewable in REVIEW PAY STATUS will still show the OLD last Name. When you search for the client forms in REVIEW PAY STATUS- Search by the new Primary/Principal name to pull up all forms associated with that client. If you try to search for forms with the old last name it may not give you any results. **Client Names/DCN/SSN's are false and for example only**

LESSON 2: FINANCIAL

Provider Contract Information

When clicking the 'Provider Contract Information' the financial information is automatically displayed. This screen tracks and displays the amount of funding given, amount billed, amount paid, and amount available.

The billed amount subtracts from the amount available upon submission.

If this information does not correspond with your records, contact the SMHW billing coordinator at 866-726-9926. SHMW encourages you to monitor/track your funds through your internal system.

Daily Summary of Forms Submitted

Click on the 'Daily Summary of Forms Submitted' and then click on the month and day to display. Click the arrows on the month bar to change the month and then select the day to display. This will display the client's financial information by type, date and amount.

Clicking on 'Display Full List to Print' will display the screen for sending to the default printer. Clicking on the 'Print Listing' button will generate a print job. Choose the printer on the print screen and click print. If a printout is not needed, click the 'Close' button to return to the main screen.

Sta D	te of Miss EPAF	^{ouri} RTM	ENT	° OF	H	EALT	TH AND SENIOR SERVICES	SHOW ME HEALTHY MISS
VDA FORI	CLIEN ILY SUM MS SUBN	MARY NITTE	FIN OF D	ANCI PREV FORM	(AL /IEW F /IS	PAY ST	ATUS OF PROVIDER CONTRACT	
Sh	ow Instr	uction	<u>15</u>	_	_			
Pro	ovider l	or F Vame	:	ANNC	N CC	UNTY	HEALTH DEPARTMENT	Close
<		Aj	oril 20	08		>	Select a Highlighted Date to Display Forms for	
Sı	ın Mor	Tue	Wed	Thu	Fri	Sat	this Provider for the Selected Date	
3	0 31	1	2	3	4	5		
1) / 3 14	8 15	9 16	10	11 18	19		
2	0 21	22	23	24	25	26		
2	7 28	29	30	1	2			
2	5	6			9	10		

REVIEW PAY STATUS OF FORMS

Searching for all records submitted or for a specific client is possible. There are four form status types:

- Submitted by Provider,
- Approved,
- Released to Finance for Payment, and
- Check Mailed

Each indicates a different step in the review and payment process.

Searching for a client will display all forms submitted for that client and the pay status. Click on 'Form Status' to view all clients under the criteria or click multiple items to display all the selections. (Example: 'Check Mailed')

Entering the date range will display all forms status for the range. Click the 'Search' button to display results.

State of Missouri DEPARTMEN	f of Health and Senior	SERVICES	SHOW ME HEALTHY MI
CLIENT FIN	VANCIAL ▼REVIEW PAY STATUS OF <u>PROVIDER CONT</u> FORMS <u>INFORMATION</u>	RACT	
Show Instructions			
Pay Status of Forms			
Provider Name:	SHANNON COUNTY HEALTH DEPARTME	ENT	
Client Name:	Last:	First:	
Form Status:	Submitted By Provider	Approved	
Uncheck All	Released To Noance For Payment	Check Mailed	
Wsit Date Range:	Benin Date	ind Date:	
			Search Clear Close

REVIEW PAY STATUS OF FORMS, CONTINUED

The 'Form Type' and 'Total Amount Paid' columns show in blue. Clicking on either one brings up the form or the claim screen to review. **The claim screen form is 'read only'.**

State of Missouri DEPARTMEN	I OF HEALTH AN	d Senior S	ERVICES	SHOWI	ME HEALTHY M
CLIENT FIN	NANCIAL ▼REVIEW PAY STATUS OF► FORMS <u>II</u>	PROVIDER CONTRANS	<u>4CT</u>		
Provider Name:	SHANNON COUNTY HEA	ALTH DEPARTME	NT		
Client Name:	Last:		First:]
Form Status:	Submitted By Provider		Approved		
Uncheck Al	Released To Finance For Paym	ent	Check Mailed		
Msit Date Range:	Begin Date:		End Date:		
					Search Clear
Client Name at Time of Visit Visit	Amt Date Form Type Billed	Original Amt Paid Ac u	stment Amt Paid		Status Warrant Date
ROSES, MERRY 04/16	1008 Screening 50.00		\$0,00 \$0.00	SUBMITTED BY PI	ROVIDER
1					

REVIEW PAY STATUS OF FORMS, CONTINUED

Clicking on the 'Amount Billed' link will display the detailed information for that client and date. **This form is 'read only'.**

State of Missouri DEPARTMEN	T OF HE	EALTH AND SENI	IOR SERVIC	CES	SHOW ME	HEALTHY	MISSOURI
CLIENT F	INANCIAL						User: <u>BEI</u>
DAILY SUMMARY OF	REVIEW P	AY STATUS OF PROVIDER	CONTRACT				
PORMS SUBMITTED	PORMS	INFORMATIO					
Show Instructions							
CLAIM DETAILS							
Client Name :	ROSES, ME	ERRY		Form Type :	SCREENIN	3	
Visit Date :	4/16/2008	3		Visit Type :	Initial		
Begin Date :	4/16/2008	3		End Date :	4/16/2008		
Total Amount Billed :	\$0.00			Total Amount Paid :	\$0.00		
SERVICE DETAIL	.\$	Fund for Payment	Amount	Amount	nts		
OFFICE OUTPT N	EW 30 MIN		<u>Billed</u> \$0.00	<u>Paid</u> \$0.00			
1		Total Amount Billed	on Services: \$().00 Total Ar	mount Paid on	Services: \$	50.00
			<u>Close</u>				
CPT™ only Copyright listings are included for data contained he	: 2004 Americ in CPT™. AMA erein.	an Medical Association. All a does not directly or indire	rights Reserved. 1 ctly practice media	lo fee schedules, l ine or dispense m	basic unit, relativ edical services. A	e values or rela MA assumes n	ated o liability
👸 Done						🔍 🔍 Loca	I intranet

Address questions and general assistance requests to the central office staff by calling SMHW/WISEWOMAN at 866-726-9926.

Direct specific questions or concerns with MOHSAIC to the ITSD Help Desk 800-347-0887 or by e-mail at support@health.mo.gov.

SHOW ME HEALHTY WOMEN FORMS AND FORM ENTRY IN MOHSAIC

Show Me Healthy Women Forms Overview

All forms needs to be kept in the patient's file. Other forms that need to be included in the file, not listed below, include: Eligibility form, proof of age-photo ID, and proof of income-tax form/paycheck status.

All forms are available on the web at: http://www.health.mo.gov/living/healthcondiseases/chronic/showmehealthywomen/forms.php.

Direct any form related questions to the provider's Regional Program Coordinator (RPC).

SHOW ME HEALTHY WOMEN PATIENT HISTORY FORM (GREEN FORM)

The Patient History Form (green colored form) should be completed by each client at the initial screening visit and at every annual screening thereafter. The provider should enter the green colored form into MOHSAIC when reporting the initial screening visit and update the information each year as needed.

MISSOURI DEPAP BUREAU OF CAN SHOW ME HEALT PATIENT HIST (TO BE COMPLET	RTMENT OF HE. CER AND CHRO THY MISSOURIA TORY TED BY CLIENT	ALTH AND SENI DNIC DISEASE C .NS/SHOW ME H AND REVIEWED	OR SERVICE CONTROL IEALTHY WC	S MEN	Jet	P. O. Box 57 ferson City, MO 65102-057 (573) 522-284	
ENROLLMENT SITE/SATELLITE CLINIC (IF ANY)					DATE OF VISIT (MM/DD	/YYYY)	
A. PERSONAL HISTORY					1		
NAME (LAST, FIRST, MIDDLE INITIAL)					MAIDEN NAME		
E-MAIL ADDRESS		HOME PHONE NO.		WORK PHO	DNE NO.	GELL PHONE NO.	
	()		()				
STREET ADDRESS	CITY/STATE	ZIP CODE					
DATE OF BIRTH (MM/DD/YYYY)	UMBER (OPTIONAL)	WHAT I	S THE PRIMAR	Y LANGUAGE SPOKEN IN	YOUR HOME?		
		🗆 English 🛛 Spanish 🔲			Other		
NUMBER OF HOUSEHOLD MEMBERS	INSURANCE COVERA	AGE:	1			MEDICAID DCN/MEDICARE NUMBER	
	□ None	□ Mo HealthNe	et 🗆 Medicare 🗆 Private				
 (1) White (2) Black or African American (3) Asian (4) Native Hawaiian or Other (5) American Indian or Alaska (6) Other (7) Unknown (please avoid u 	Pacific Islander an Native sing)		Are you Highest gra (U. S. e 1 2 3 4	of Hispani de of scho quivalent i 4 5 6	ic origin? □ ol completed (circle f educated in anoth 7 8 9 10 11	Yes □ No e one) her nation) I 12 13 14 15 16	
How did you hear about the Show M (please choose only one) (1) Physician (8) (2) Clinic (9) (3) Television (10) (4) Radio (11) (5) Printed Ad (12) (6) Billboard (13) (7) Bus Sign (Sp	Me Healthy Wom Health Care F Health Fair Health Coaliti Outreach Wor Outreach Wor Healtive/Frien Other Locatio ecify)	en program? Provider on ker d n	What type of appointmen (1) (2) (3) (3) (4) (5) (6) (7) (8)	of transpor t? (please Bus ACT Van OATS Bus Taxi Personal \ Relative/F SMTS Other	tation did you use t choose only one) ; /ehicle riend	o get to your clinic	
Date of last Pap Test/_			Date of Las	t mammog	jram//	/	
Do you now smoke cigarettes?	🗆 Everyday	/ □ So	me days	□ Not at	all 🗆 Do	n't know	
Name and telephone numbers of tw	o people who ca	in always reach y	ou:				
NAME		HOME PHON	E WITH AREA COE	E	WORK PHONE		
INAMIE		HOME PHON	E WITH AREA COD	E	WORK PHONE		
		I			1		

SHOW ME HEALTHY WOMEN SCREENING FORM (BLUE FORM)

The Screening Report Form (blue form) should be submitted at the initial, rescreen, an annual screening for all client's participating in SMHW. Document the first mammogram a client receives on the screening form.

NROLMENT SITE/SATE/LITE SITE INAME AND A	ADDRESS)					REFERRING	PROVIDER / FOR	DIRECT	BILLING)
							and the subject of the	- 211 12:0	
PERSONAL DATA									
AME (LAST, FIRST, MIDDLE INITIAL)					1	SOCIAL SEC	CURITY NUMBER		
ATE OF BIRTH	CLIENT ELIGIBILITY VERIFIED	INSURANCE	OVERAGE	DEDUCTIBLE	MET REFE	RRAL FEE	MEDICARE		
MM DD YYYY	Yes D No	Ves	I No	C Yes C	No	9	D Part A	0	Part A and B
ISIT TYPE I Initial I Annual	Rescreen	Height	Weight	BMI	Blood Press	sure tat New	cingl	_	
Initial CBE only Annual CBE onl	ly 🗆 Mammogram only	t n.	lbs		-	2rd Ne	acing/		
BREAST CANCER SCREEN	NG								Reporting Onl
B 1. Does client report any BSE sy	ymptoms? TYes N	la (IT "YES" con	mplete B2.)	Date	of CBE	1			7
B 2. Symptoms Reported By Client	t (Check any that apply. If 1,	2, 3 or 4B Is che	ecked, may	have two (2) di	lagnostics a	t clin/clan*	s discretion.)		
(1) Lump		🗆 (4A) Pain/Te	nderness - 1s	st occurrent	ce D(4B) Pain/Tend	ernes	s - 2nd occurrence
(2) Nipple discharge		□ (5)	Other (s	ecify)					
(3) Skin changes (dimpling, retrac	tion, new nipple inversion,								
uiceration, Paget's disease)									
B 3. CBE within normal limits and fi	indings Present at CBE	(check yes or i	no and one	explanation)					
Yes Vithin normal limits									
D(1) Benigh finding (fibrocystic	c changes, diffuse lumpiness,	clearly defined	thickening,	tendemess or	r nodularity)				
DNo - Suspicious for cancer (A	Any checked findings requi	res completio	n of two (2) diagnostic	procedure	s entere	d on purple br	east fo	nm.)
diffuse, poorly defined this	ickening, cystic or solid)	口 (5)	Skin dimp	ing retraction; i	new nipple i	inversion;	peau d'orange; u	liceratio	on; one breast
(3) Nipple discharge		71.(5)	lower than Enlamed	lusual; promin	ent veins, u	nilateral; u shie sunra	inusual increase	in size	, unilateral
(4) Nipple or areolar scaliness	s or erythema	- (o)	lymph noc	les: also swelli	ng of upper	am am	warroundr, mital	ACT VICULE	in on axinary
B.4. Risk for Breast Cancer mith	Auston			Net second	rad				
	Average High/Increased) Not assess	sed				
94	right instance		-1-						
Rescreen CBE Planned Ves D	0 No /		Diagnos	tic Work-up	p Planne		1Yes □No		
(must be less than 10 months)			Mutat p	e ress triain do daj	M	M DD	YYYY		
B.5. Mammogram Results									Reporting On
D (4) Mampagam pat data at C	PE does had	0.0	Consideral to	oord aniv no h	mant cando	o otovádov			
diagnostic workup planned	DE UUTIE d'IU	L (6)	Referred to	direct biller	redat servic	e provided	1.000		
 (1) Routine screening mammograph 	ram	D (3)	Abnormal	mammogram d	tone by a no	on-program	n funded provide	er, patie	int referred in for
 (2) Mammogram performed to a CL Positive BSE 	evaluate symptoms:		diagnostic	evaluation (En	iter results i	n Mammo	gram field as Re	porting	(Only)
D Positive CBE			Date client	referred for di	agnosis.		//_	_	_
Previous abnormal man	mmogram results (rescreen)					MM	00	YYYY	
Mammography provider facility						_			Mammonram Var
ifacility name/city/	1967 A. M. 1987							-	and an
Previous mammogram 🛛 Yes 🗆 No	o 🗆 Unknown Date of	last mammo	gram	/	Date of	this ma	mmogram _	1	1
Type of mammogram	ng 🖸 Diagnostic			Method us	sed for n	ammoo	ram DD	gital	Conventional
SMHW mammogram result (check o	ne) (results with * require a	daltional follow-	up)						
Left Right (Indicate why only one b	breast had mammogram in COI	MMENTS)	Left F	Right					
Normal (1) Negative (Category	1)	Abino	ima 🗆 🛙	(3) Probab	iy Benign ((ategory 3	atononi di		
(2) Benign Finding (Cate	egory 2)			1 (4) SUSPIC	Suggestive	manty (C	alegory 4)	N 51*	
Further diagnostic planned for: (3) Proba	ably Benign: 🗆 Yes 🗆 No	0		(14) Need e	valuation or	film comp	arison (Categor	v o	
Rescreen mammogram planned	D Yes D No D	iagnostic wo	rk-up pla	ned D Ye			and a surger	- 1-	
(must be less than 10 months)/		imust be less than	60 days)						
NM YYY	et hill /nhusisian/haithe a	amal	Charles Street	MM C	DD	mm			
THE REPORT OF THE PROPERTY OF	eta one <i>innySician/tacility n</i>	entel							
Referred for diagnostic testingrane	and the first stand in								

	xam only (1) Routine Pap tas (2) Patient under su (4) Pap tast not dor (6) Referred to dire (3) Abnormal Pap te	t inveillance for previous abr re. Patient proceeded direc ct biller for Pap and Pelvic est done by non-program p	normal (rescreen) zty for diagnostic work-up or HPV rovider - reporting only/referral da	testing le <u>//_vvv</u>	Risk for Cervical Cancer (1) Average (2) High/Increased (4) Not assessed (5) Unknown			
C 1. Pelvic Exam Re	esults	C 2. Pel	vic Exam Findings		C Reporting Only			
Pelvic Exam WNL? (Additional information req Hysterectomy? Cervix absent Cervix absent di (needs annual P Cervix present Reason for hyste	Yes D No Ulred In "No" selected, See C 2.) Yes No ue to cervical cancer ap test) erectomy unknown	Findings 1) Carv 1 1 1 1 1 1 1 1 1 1 1 1 1	Findings Present at Pelvic Exam (check only one)					
Date of Peivic Exam Reproductive Status (ch a) Premenopaus b) Postmenopau	INN DO YYYY Ieck one) al Isal	2) Exar Rescreen Diagnostic (must be A	n Complicated by Obeelty planned D Yes D ! : planned D Yes D ! :ssthar 90 days)	No / / / No / / / No / /				
C 3. Pap Test Result	ts				Reporting Only			
Previous Pap Isst Specimen adequacy	Yes No Unknown Satisfactory Unsatisfactory due to Unknown	Date of	Isst Pap test / MM YYYY Specimen type Conver Uquid I Annual	Date of this Pap test ntional Smear Based Pap due to previous treatment f	MM DD YYYY			
Endocervical Cells	(ASC-US)(May have HP) (4) Lowgrade StL (HPV/Mit) (5) Afypical Squamous Cel (6) Highgrade StL (with fea	v test) 1 Dysplasla/CIN I)* Is, cannot exclude HSIL (itures suspicious for invas	(ASC-H)* [] (10) ION/CIN II-II/CIS)* [] (11)	Adenocarcinoma in situ Adenocarcinoma Other				
	e / / MM	אייייסט			Reporting Only			
C 4. HPV Test Date	(1.(1) Coloring Serenging	HPV Test Result	(1) Positive (High Risk)	HPV DNA Genotype 16 or 18	ST 1. 27			
C 4. HPV Test Date	(1) Collessing Screening (2) Triage (Reflex) (3) Not Done (9) Unknown		(2) Negative	negative and HPV High Risk G □ Yes □ No □ No Test Performed	Positive (Only report if Pa sroup Positive)			
C 4. HPV Test Date Indication for HPV Test Rescreen Pap plann (less than 10 months)		-/	(2) Negative iagnostic work-up planned nust be less than 00 days)	Inegative and HPV High Risk G	Positive (Only report if P) shoup Positive) d <u>/ / /</u> MM DD YYYY			
C 4. HPV Test Date ndication for HPV Test Rescreen Pap plann less than 10 months) Referred for diagnos physician/facility name)		-/	(2) Negative iagnostic work-up planned nust be less than 00 days)	Inegative and HPV High Risk G	Positive (Only report if P) shoup Positive) d <u>J J</u> MM DD YMY			
C 4. HPV Test Date Indication for HPV Test Rescreen Pap plann (less than 10 months) Referred for diagnos (physician/facility name) Date of next routine F D. COMMENTS			(2) Negative Hagnostic work-up planned nust be less than 00 days)	negative and HPV High Risk G	Poetitive (Only report if P) inoup Positive)			

SHOW ME HEALTHY WOMEN BREAST FORM (PURPLE FORM)

Breast Diagnosis and Treatment Form (purple form) should be completed for all clients with abnormal breast cancer screening results that require further diagnostic procedures and/or treatment.

	BUREAU OF CANCE SHOW ME HEALTHY BREAST DIAGN	R AND CHRONIC DISEA MISSOURIANS/SMHW	SE CONTROL					Jefferson	City, MO 85102-0570 (573) 522-2848
ENROLLMEN	T SITE/SATELUTE (NAME AND AD	DRESS)		1	REFER	RING PROVIDER (FORDIRE	ECT BILLING)	
	Contract on the local diversion of the					_			
A. PERS	ONALDATA								
NAME (LAST,	FIRST, MIDDLE INITIAL)								
DATE OF BIR	TH	SOCIAL SECURITY NUMBER				- 1	CLEATE	KO BUTY VER	ielen
		-	Q			1000	O Yes		No
INSURANCE	COVERAGE	DEDUCTIBLE MET	REFERRAL FEE	TYPE	OFMEDI	ARE		BOCT	
C Yes	LI NO	I Yes I No		D Pa	rt.A	D Part A a	nd E	I Yes	D No
B. BREAS	ST DIAGNOSTIC PROC	EDURES	3						Reporting only
Diagnost	ic Mammogram 🛛 🗆 🗠	onventional C Diattai							
Additiona	al Mammographic view	r(s)	MM BD	mm					
Normal Abnormal		ategory 1) ing (Category 2) nign (Category 3) Abnormality (Category 4) stive of Malignancy (Category 5	5)						
Ultrasour	nd ; ,	aging Pending (Category 0)							D Burnting and
	MM DD YYYY	5		_			1	J Rescree	en 🗆 Reporting oni
Left: Right:	Complete Limited Complete Complete Limited		Norm Abno Other		 □ (1) □ (2) □ (3) □ (4) □ (5) □ (7) 	Negative (Ca Benign Findir Probably Ber Suspicious A Highly Sugges Refer to BCC Unsatisfactor	ategiory ng (Cate nign (Ca bnorma stive of M CT y - not i	1) egory 2) ategory 3) ality (Categ Malignancy interpreted	ory 4) - Refer to BCCT (Category 5) - - repeat (not paid)
Specialist	Consultation Date	Diagn	ostic Work-up Planne	d 🗆 No	ne 🗆	0-80 days (G 61-90) days	Reporting onl
CBE WNL	. □Yes □ No (If "N	lo" indicate finding below)						
Benign fin Suspiciou	Inding (1) Fi s for cancer (2) Di: (3) Nin (4) Nin (5) Sk pr (6) Er	brocystic changes, diffuse lu screte palpable mass ople discharge pple or areolar scaliness or e in dimpling, retraction, new n ominent veins, or unilateral in inlarged, tender, fixed, or hard	mpiness, clearly defin nythema hipple inversion, peau norease in size I palpable supraclavic	ed thick d [°] orang ular, infr	ening, (e, ulcer aclavici	or nodularity ation; also one ular, or axiltary	e breast lymph	t lower thar nodes; als	n usual; or unilateral o swelling of upper arm
Fine Nee	edle/Cyst Aspiration	M DD YYYY	Cytopathology P	erforme	I 🗆 Ye	s 🗆 No			Reporting only
Left Brea	ast			Right B	reast				
Туре	Superficial Deep tissue under o	uidance		Гуре		Superficial Seep tissue up	der qui	dance	
Result	(1) Negative (2) Indeterminate (3) Suspicious for M (4) Malignancy - Refe	alignancy - Refer to BCCT		Result) Negative) Indeterminat) Suspicious f	e for Mali	gnancy - R	efer to BCCT

Location D Physician Office D Hospital outpatient Facility Fee DYes No		L Reporting only
	Anesthesia 🗆	
Primary Biopsy Type: Clear	and the second s	
Breast Percutaneous		
Left Right Stereotactic Guided (19081) US Guided (19083) Needle Core, No Guidance (19100)	Add Lesion	Additional Primary Pathology No additional pathology 1 additional pathology
□ Incisional, No Guidance (19101) □ Mammogram Guided (19281) □ Stereotactic G □ Excisional (19120 or 19125) Preoperative placement of clip? □ Yes □ No Radiological exam? □ Yes □ No	Guided (19283) 🔲 US Guided (19285)	2 additional pathology 3 additional pathology
Additional Lesion: Clear		
Incisional, No Guidance (19101) Imammogram Guided Stereotactic Excisional (19120) Excisional (19120) Radiological exam? Yes D No	Guided 🔲 US Guided	Additional Primary Pathology No additional pathology 1 additional pathology 2 additional pathology 3 additional pathology
Additional Facility Fee 🗆 Yes 🗆 No		
Bioney Docult /Boost calls most cause poulti Statue of Figal Disc	mosis	
Diopsy Result (Report only most severe result) Status of Final Diag	nosis	
(2) Benjan/Atvoical (1) Work-up C	Complete (Complete Section C)	
(3) Indeterminate (2) Work-up	renaing plaw-up (Enter Lost to Follow-up Data	in Final Diagnosis Data
(4) Malignancy (3) Lost to P	Potisod (Decembe in semant estime	furt have signed univers
	able (Describe in coment section)	- Describe)
Next Breast Cancer Screening Date	···· (····· ··· ··· ··· ··· ··· ··· ···	
Other Procedure (specify):	Other Procedure Date:	
	Y	
	MM DD YYYY	
C BREAST DIAGNOSIS		
(1) (A) Lobular Caminama In Situ /I CIEL (Chass Olt		
(5) Ductal Carcinoma In Situ (DCIS) (Stage 0)* (2) Invasive Breast Cancer*		
(a) Looplan Garcinoma in Situ (LCIS) (Stage 0)* (b) Ductal Carcinoma in Situ (DCIS) (Stage 0)* (2) Invasive Breast Cancer* Final Diagnosis/Imaging Date		
City Ecologia Carcinoma In Situ (ECIS) (Stage 0)* (5) Ductal Carcinoma In Situ (DCIS) (Stage 0)* (2) Invasive Breast Cancer* Final Diagnosis/Imaging Date // MM DD DD DD		
	Тупе	
D (*) Lobal Carcinoma In Situ (DCIS) (Stage 0)* (5) Ductal Carcinoma In Situ (DCIS) (Stage 0)* (2) Invasive Breast Cancer* Final Diagnosis/Imaging Date //// DD/ DD/ DD/ DD/ DD/ DD/ DD/ DD/ DD/ DD/	Туре	
Control Carcinoma In Situ (DCIS) (Stage 0)* Control Carcinoma In Situ	Type □ (1)Surgery	
	Type (1) Surgery (2) Radiation	
D. BREAST TREATMENT Status of Treatment (1) Started (2) Pending (3) Lost to F/U (Describe in comment section) (4) Refused (Describe in comment section) (5) (5) Refused (Describe in comment section) (5) Refused (Describe in comment sect	Type (1) Surgery (2) Radiation (3) Chemotherapy (4) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	
	Type (1) Surgery (2) Radiation (3) Chemotherapy (4) Hormone	
	Type (1) Surgery (2) Radiation (3) Chemotherapy (4) Hormone (5) Immunotherapy	
	Type (1) Surgery (2) Radiation (3) Chemotherapy (4) Hormone (5) Immunotherapy (6) Other Cancer The	гару
	Type (1) Surgery (2) Radiation (3) Chemotherapy (4) Hormone (5) Immunotherapy (6) Other Cancer The Specify_	гару
	Type (1) Surgery (2) Radiaton (3) Chemotherapy (4) Hormone (5) Immunotherapy (6) Other Cancer The Specify	гару
	Type (1) Surgery (2) Radiation (3) Chemotherapy (4) Hormone (5) Immunotherapy (6) Other Cancer The Specify	гару
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	Type (1) Surgery (2) Radiation (3) Chemotherapy (4) Hormone (5) Immunotherapy (6) Other Cancer The Specify	гару
	Type (1) Surgery (2) Radiation (3) Chemotherapy (4) Hormone (5) Immunotherapy (6) Other Cancer The Specify	rapy
	Type (1) Surgery (2) Radiation (3) Chemotherapy (4) Hormone (5) Immunotherapy (6) Other Cancer The Specify	rapy
	Type (1) Surgery (2) Radiation (3) Chemotherapy (4) Hormone (5) Immunotherapy (6) Other Cancer The Specify	rapy

SHOW ME HEALTHY WOMEN CERVICAL FORM (YELLOW FORM)

Cervical Diagnosis and Treatment Form (yellow form) should be completed for all clients with abnormal cervical cancer screening results that require further diagnostic procedures and/or treatment.

		the transfers					
ENROLLMENT SITE/SATELLITE (NAME AND)	ADDRESS			REFERRING PRO	VIDER (FOR	DIRECT BILLING)	
A. PERSONAL DATA					_		
	SOCIAL SECURITY NU	JMBER	- 11		CUENTE	LIGIBILITY VERIFIE	0
	DEDUCTIBLE MET		TYPE OF	MEDICARE DPartA and B		BOCT	
B. CERVICAL DIAGNOSTIC	PROCEDURES		1				
Specialist Consultation	MM DD YYYY						C Reporting Only
Diagnostic Work-up Planned	D None D 0-60 Day	ys 🗆 61-90 days					
Colposcopy without Biopsy	MM DD - YYY	Ŷ					Reporting Only
Colposcopy	1 10 1111						Reporting Only
D Polypectomy	1						C Reporting Only
Cervical Biopsy Cervical Biopsy/EC Endocervical Biopsy/Ca Colposcopy inadequate, n	C Biopsy an only be reimbursed need further diagnostic	with cervical biopsy) 🛛	1 Additiona 2 Additiona 3 Additiona	al Cervical Biops al Cervical Biops al Cervical Biops	sy lies lies		
Cervical Biopsy Cervical Biopsy/EC Endocervical Biopsy/EC Colposcopy inadequate, n Diagnostic procedures, choos	C Biopsy an only be reimbursed need further diagnostic se ONLY one	with cervical biopsy)	1 Addition: 2 Addition: 3 Addition:	al Cervical Biops al Cervical Biops al Cervical Biops	iy ies ies		D Reporting Only
Cervical Biopsy Cervical Biopsy/EC Endocervical Biopsy/EC Colposcopy inadequate, n Diagnostic procedures, choos	C Biopsy an only be reimbursed need further diagnostic se ONLY one	with cervical biopsy)	1 Addition: 2 Addition: 3 Addition:	al Cervical Biops al Cervical Biops al Cervical Biops	sy ies ies		□ Reporting Onl
Cervical Biopsy Ca Colposcopy inadequate, n Diagnostic procedures, choos CLEEP	C Biopsy an only be reimbursed need further diagnostic se ONLY one Cold P Cold P (1) (2) (3) (4)	with cervical biopsy)	1 Addition: 2 Addition: 3 Addition:	al Cervical Biops al Cervical Biops al Cervical Biops	sy iles iles cal Curett	age (alone)	Reporting Onl
Cervical Biopsy Cervical Biopsy/EC Colposcopy inadequate, n Diagnostic procedures, choos CLEEP Cervical Procedure	C Biopsy an only be reimbursed need further diagnostic se ONLY one Cold H (1) (2) (3) (4)	with cervical biopsy)	1 Addition: 2 Addition: 3 Addition: 9 MYY	al Cervical Biops al Cervical Biops al Cervical Biops	sy iles cies	age (alone)	Reporting Only
Cervical Biopsy Cervical Biopsy/EC Colposcopy inadequate, n Diagnostic procedures, choos CLEEP COR Other Cervical Procedure Next Cervical Cancer Screenin	C Biopsy an only be reimbursed need further diagnostic se ONLY one Cold I (1) (2) (2) (3) (4) (specity)	with cervical biopsy)	1 Addition: 2 Addition: 3 Addition:	al Cervical Biops al Cervical Biops al Cervical Biops	sy sies sal Curett	age (alone)	Reporting Only
Cervical Biopsy Carterial Biopsy/EC Endocervical Biopsy/EC Carterial Biopsy (Ca Colposcopy inadequate, n Diagnostic procedures, choos Carterial Ca	C Biopsy an only be reimbursed need further diagnostic se ONLY one Cold I (1) (2) (3) (4) (specity) mg Date	with cervical biopsy)	1 Addition: 2 Addition: 3 Addition: 	al Cervical Biops al Cervical Biops al Cervical Biops	sy sies sal Curett	age (alone)	D Reporting Onl

Diagnosis (RECORD MOST SEVERE RESULT)	(Diagnostic results with (*) require treatment)
 □ (1) Normal/Benign Reactive/Inflammation □ (2) HPV/Condytomata/Atypia □ (3) CIN I/Mid Dysplasia/Low grade SIL (Bio □ (4) CIN II/Moderate Dysplasia (Biopsy Dia □ (5) CIN III/Severe Dysplasia/High Grade □ (6) Invasive (Biopsy Diagnosed)' (Refer t □ (7) Other 	psy Diagnosed)" Ignosed)" (Refer to BCCT) SIL/Carcinoma In Situ (CIS), Stage 0 (Biopsy Diagnosed)" (Refer to BCCT) o BCCT)
Diagnosis Date	
ERVICAL TREATMENT	
Status of Treatment Started Pending Lost to F/U (Describe in comment sec Work up refused (Describe in commer Not Needed	tion) It section/Must have signed waiver)
Type Cryotherapy Conization (LEEP, Cold Knife) Radiation Therapy Chemotherapy Surgery Immunotherapy Other Cancer Therapy - Specify	
tment Facility Ity Name/City	
Treatment Started /	2027
ments	

Show Me Healthy Women Claim Entry

Before submitting any claims, application for access to MOHSAIC must be made. Approval for access will be granted within approximately one week. Please see MOHSAIC section of this manual (starting page 3) for further instructions.



SHOW ME HEALTHY WOMEN CLIENT ELIGIBILITY

CLAIM SUBMISSION

Entering or Viewing a Client

The main screen for the SMHW program appears. To enter or view a client:

- Click on the 'Client' link on the menu bar
- Choose 'Submit New Forms/Billing'

DEPARTMENT OF HEA Current Client: None Selected	LTH AND SENIOR SERVICES	SHOW ME HEALTHY MISSOURIANS	User: <u>BETAD</u>
CLIENT PROV DER	L ADMINISTRATIVE Development AID INFORMATION		
	WELCOME 1	Ο	
	MOHSLIC		
Donë		Loc	cal intranet

Client Search

In 'Submit New Forms/Billing' screen under the 'Client Information' section, choose either to 'Search and Select' or 'Register a New Client.'

Type the Social Security Number (SSN) with no spaces or hyphens; the Departmental Client Number (DCN) or the last and first name of the client separated by a comma (Example: Doe, Jane). **Do not click return – wait until drop down menu appears.**

If the screen returns more names than the screen will hold, use the scroll down bar to see the full screen. If there are more than 15 names on the screen use the double arrow at the bottom of the screen to proceed to the next search result screen.

State of Missouri DEPARTM	ENT OF HEALTH AND SENIOR SER	VICES	SHOW ME HEALTHY MISSOURIANS
Current Client, N	tone Selected		
CLIENT	PROVIDER FINATCIAL ADMINISTRATIVE	Development	
SUBMIT NEW FOR	MS/BILLING		
Show Instructions			
Submit Forr	n		
Client Information	n		
Client Name	• ?	Update Client Informa	tion
Address		SSN	Sex
		DOB	Race
		DCN	Ethnicity
City, State Zip	▼, MO ▼ Pho	ne 🗌 - 🗌 -	No Phone
Provider Informa	tion		
	C Regular Billing C Direct Billing		
Provider	— R:	eferring Provider	-
Service			
Name/Address	an a		
Type			
Version			Create Form Close
ļ			
🔊 Done			

Searching for Current Client

If the client name appears, then select the correct name by clicking on it. Verify the name by checking the date of birth (DOB) and DCN number, if available. The client may be in the system with multiple names. Choose the name of the client as she presents to you. If not available, select one and then correct with 'Update Client Information.'

The client information screen will display the client demographic information. If any information is missing, add the correct information in the 'Update Client Information' screen.

If the client name is not in the database, this screen will say 'No Results Found'. Press the tab key to continue.

State of Missouri	1ENT OF H	EALTH AND SEN	IOR SER	VICES s	HOW ME HEA	ALTHY MISS	OURIANS
Current Client:	None Selected						
CLIENT	PROVIDER	FINANCIAL ADMIN	ISTRATIVE	Development			
SUBMIT NEW FO	RMS/BILLING	VIEW MEDICAID INFORM	MATION				
Show Instruction	IS						
Submit For	m						
Client Informati	on						
Client Name	jane, doe	- ?	(Update Client Informatio	on 🔪 📒		
Address	2 of 2 retrieved.	. Make a selection, Refine	Search or Pr	tab key to continue			
Address	Name	DOB	DCN	Address		PartyID	
	JANET, DOE M		123456	78		378223108	
	JANET, DOE M		123456	78		378223116	
City, State Zip							
Provider Inform							
Provider							
Service							
Name/Address	J						
Form Type / Vers	ion						
Yeusian					Create Form	Close	
Version	I				orouto r orini		
<i>(</i>							

Adding a New Client

If the client name does not appear, then hit the 'enter' or 'tab' key and the message to add a new client appears. Click the 'OK' button and proceed to the 'Add Person' screen.

CLIENT	lone Selected PROVIDER FINANCIAL ADMINISTRATIVE Development
SUBMIT NEW FOR	MS/BILLING
how Instructions	
Submit For	n
lient Informatio	Microsoft Internet Explorer
Client Name	ane, doe
Address	The client was NOT found in MOHSAIC. Click OK to add the client. Click CANCEL to search again.
City, State Zip	OK Cancel
Provider Informa	
Provider	Referring Providex
Service Name/Address	A Contraction of the second seco
form Type/Versio	n
Type	
	Create Form Close

The search will check the MOHSAIC and DSS databases. If the client name is not in the system, the screen appears with the 'No results found matching search criteria.' Click the 'Create New Client on MOHSAIC' link.

🗿 QuickClient	Add Web Page	Dialog		×
Add Person				
Show Instructions				_
Client				
Last Name *	CORRECT	First Name * Middle Name	IMA	
Suffix		Prefix		
Date of Birth *	3/21/1952	Gender *	FEMALE	
Ethnicity *	NON HISPANIC	SSN		
Race *	AMERICAN INDIAN -	CHIPPEWA		
Search Create New C	lient on MOHSAIC Modify Sea	rch Cencel		_
No recults found mat	obina coprob oritoria			
No results Iounu mat	ching search chiena.			
	_			

Adding new client, continued

The 'Client Information' screen is displayed. The next step is to enter the address and telephone number. Then proceed to the 'Provider Information' section or view Medicaid information.

State of Missouri DEPARTM	ENT OF HEA	LTH AND SE	NIOR SEE	RVICES	SHOW		MISS
Current Client: RE	ALGET No Addres	ss Found No Phone Ir	nformation Found		511011		Us
CLIENT	FINANCIAL						
SUBMIT NEW FOR	MS/BILLING <u>V</u>	IEW MEDICAID INFO	RMATION				
Show Instructions	3						
Submit For	m						
Client Informatio	n						
Client Name	REAL, GET	•	2	Update Client In	formation		
Address				SSN 555-66-5 DOB 12/12/19 DCN 63045647	551 Sex 51 Race 7 Ethnicity	FEMALE WHITE NON HISPANIC	
enty, State Zip		▼, MO ▼	Pho	ne 🗌 - 📃	r	No Phone	
Provider Informa	ation						
	O Regular Billi	t Billing					
Provider	SHANNON COUNTY	HEALTH DEPARTME	NT 🔽 R	eferring Provider			~
Service Name/Address	OREGON COUNTY HE	ALTH DEPARTMENT - 1	19 GREY JONES	STREET, EMINENC	E, MO 65466		•
Form Type/Versi	on						
Туре			-				
Version			-		Create	e Form Clos	e
-							1

Address Verification

If the system does not recognize the address, 'Address Verification' will pop up. If the address is correct, enter the county and click "save." Or, change the address to a valid address and click save.

If the county and address match the database, the pop-up box will turn orange. If not, and both fields are correct, call SMHW at 866-726-9926 to request an address fix. Normally this fix will be done overnight.

Popup Web Page Dialog	×
rification	
entered could not be completely verified. ddress could not be validated or multiple addresses were found that could the address being entered. of the possible addresses or accept the address as entered.	d
ition	
NOTE: This address will be marked as OVERRIDE. 164 SYCAMORE LN JEFFERSON CITY, MO 65109 County	
No valid addresses were found.	
	Popup Web Page Dialog rification entered could not be completely verified. ddress could not be validated or multiple addresses were found that could the address being entered. of the possible addresses or accept the address as entered. the possible addresses or accept the address as entered. NOTE: This address will be marked as OVERRIDE. 164 SYCAMORE LN JEFFERSON CITY, MO 65109 County

Checking for Medicare/Medicaid

If the client name is not on Medicaid, the screen will be empty. The 'View Medicaid Information' is transferred from the DSS database. **This screen is 'read only'**. The screen will display the current client at the top of the screen.

If a client name is displayed at the top of the screen and is on Medicaid, the screen will be filled in.

State of Missouri DEPARTMENT OF HEALTH A	ND SENIOR SER	RVICES	SHOW ME H	IEALTHY I	MISSOURIA User: <u>BETA</u>
CLIENT FINANCIAL					
SUBMIT NEW FORMS / BILLING	CAID INFORMATION		-		
Client - ROSES, MERRY Chang	<u>le Client</u>				
Client's Medicaid Status					
Status	Status Date				
Parent/Guardian Medicaid Case Info	ormation				
DCN		Status			
Telephone					
Address 1					
Address 2					
City		State	Zıp		
Client's Medicaid Dates					
Begin Date End Date	Program	Leve	el Of Care	ME Code	
					1
Client's Managed Care(Medicaid On	ly)				
Plan	Begin Date	End Date	Plan Number		
1					
	<u>Clo</u>	se			
Done				Nocal i	intranet

This screen shows all of the client and guardian (if applicable) information as well as the managed care information. If there is an open date but no close date, the client is on some sort of assistance.

State of Missouri	MENT OF HEALTH A	ND SENIOR SE	PVICES	<u>cuow</u>		
DEFART	MENT OF HEALTHA	IND SEINOR SE	KVICL5	SHOW	ME HEALTH	Ilear F
CLIENT			F Development			Osei. <u>i</u>
SUBMIT NEW F	ORMS / BILLING	CAID INFORMATION				
0000000						
Client's Me	edicaid Status					
Status	0	Status Date				
Parent/Gu	ardian Medicaid Case Inf	ormation				
DCN	18053885		Statu	s 5		
Telephone						
Address 1	1007 INTL AVE	30X 605				
Address 2						
City	JOPLIN		State	МО	Zip 64801	
Client's Me	edicaid Dates					
Begin Date	EndPate	Program	L	evel Of Care	ME Code	
9/1,2002	5/28/2006	AC				
9/1/2002	5/28/2006	AC				
9/1/2002	5/28/2006	AC				
1						
Client's Ma	naged Care(Medicaid On	ly)				
Plan		Pegin Date	End Date	Plan Numl	ber	
		•				
		-	lose			
		<u>~</u>				
s'i						al intranat
2						arinuariet

Please remember when pulling up or entering another client under client demographics, <u>verify</u> the client address and other personal information is correct. We have encountered several forms that were entered for a different client, but only the client name was changed. This leads to duplicate records in the system and results in errors on the data submitted to CDC. Until a software programming change is complete, please make sure the date of birth and SSN are correct for the client form being entered.

Entering Provider and Form Type Information

On the 'Provider Information' section, select either 'Regular' or 'Direct Billing'. If 'Direct Billing' is selected, a referring provider must be entered. Type in the provider's name and select the appropriate provider. If 'Regular Billing' is selected, a referring provider is not necessary.

When entering information in this section is complete, proceed to the next section – 'Form Type/Version.'

This screenshot has two points to consider. When a form is selected, the version will populate with available demographics. During the first few months of the new grant year, there could be multiple versions (such as current and previous grant year). By default, the software automatically selects the version based on the current date. To enter a form with a date of service from a previous grant year, select a different version from the 'current' version drop down box.

State of Missouri	IFNT OF HEALTH AND SENIOR SER	VICES	SHOW ME HEALTHY	MISSOU
Current Client:	DOE, JANE A 14K S EVANSTON WANSAG CITY, MO 641	08 No Phone Information I	Found	
CLIENT	PROVIDER FINANCIAL STRATIVE	Development		
SULMIT NEW FOR	RMS/BILLING DUEW MEDICAID INFORMATION			
Show Instruction	s			
Submit For	m			
Client Informatio	on Please verify address and demographics below and update	as needed.		
Client Name	DOE, JANE A 🔹 ?	Update Client Inform	nation	
Address	1234 PINEAPPLE LN	SSN 123-45-6789	Se× FEMALE	
		DOB 4/24/1949	Race WHITE	
		DCN 63045628	Ethnicity NON HISPANIC	
City, State Zip	JEFFERSON CITY - MO - 65102 Phot	ne	No Phone	
Provider Inform	ation			
	● Regular Billing ○ Direct Billing			
Provider	OREGON COUNTY HEALTH DEPARTMENT	eferring Provider		-
Service Name/Address	JONES, INDIANA K - 416 MARKET STREET, ALTON, MO 65606			•
Form Type/Vers	ion			
Туре	Patient History (Green)			
Version	Forms for Services Provided On or After June 30, 2007 💌		Create Form Clos	se
🍯 Done				

ENTERING PROVIDER AND FORM TYPE INFORMATION CONTINUED

Under the gray heading, 'Form Type/Version', click on the correct form 'Type' for the submitted information:

- Breast Diagnosis and Treatment (purple)
- Cervical Diagnosis and Treatment (yellow)
- Patient History (green)
- Screening Reporting Form (blue)
- WISEWOMAN Form (pink)

State of Missour	MENT OF HEALTH AND SENIOR SE	RVICES SHOW ME HEALTHY MISS	OU
Current Clien	IT: PERSON, NOTA 88888888 RANDOM STREET JACKSON,	KS 65109 County: ADAIR (458) 869-5236	
CLIENT	PROVIDER FINANCIAL ADMINISTRATIVE		
SUBMIT NEW	FORMS / BILLING		
Submit F	orm		
Client Inform	ation Please verify address and demographics below and updat	e as needed.	
Client Name	PERSON, NOTA 7	Update Client Information	
	· · · · · · · · · · · · · · · · · · ·	SSN SSN Not Available	
Address			
	0000000 RANDOW STREET	POR 1/1/1001 Page PACIFIC	
		BOB 1/1/1901 Race ISLANDER -	
		DCN 62217117 Ethnicity HISPANIC	
City, State	JACKSON • KS • 65109	Phane 458 - 869 - 5236	
Zip Dravidar Info			
Provider Into	Regular Billion O. Direct Billion		
Provide	er F	Referring Provider	
Servi Name/Addre	ice	V	
Form Type/V	ersion		
Ту	pe Patient History (Green)		
	Provide Strength and Transformed (Burnley)	Create Form Close	
	Cervical Diagnosis and Treatment (Purple)		1
	Patient History (Green) Screening Reporting Form (Blue)		
	WISEWOMAN Form		
	Colorectal Screening Form	Local	intra
Page: 2 of 4 1	Words: 29 🐲 🔚		1.000

ENTERING PROVIDER AND FORM TYPE INFORMATION CONTINUED

Click on the correct form 'Version': ('Forms for Services Provided On or After June 30, 20__.'). Dates must correspond with the service dates being submitted. Click on the correct form 'Version' for the submitted information:

Forms	for	Services	Provided	On or	After	lune 30	2018
			i i o viaca	011 01	AILLI	June 30,	2010

State of Missou		
DEPARI	MENT OF HEALTH AND SENIOR S	SERVICES SHOW ME HEALTHY MISSO
Current Clier	T: PERSON, NOTA 88888888 RANDOM STREET JACKS	ON, KS 65109 County: ADAIR (458) 869-5236
CLIENT	PROVIDER FINANCIAL ADMINISTRAT	IVE
SUBMIT NEW	FORMS / BILLING	
Submit F	orm	
Client Inform	ation Please verify address and demographics below and up	odate as needed.
Client Name		Update Client Information
		SSN SSN Not Available
Address	88888888 RANDOM STREET	Sex FEMALE
	1	DOB 1/1/1901 Race PACIFIC
		ISLANDER -
		Edinicity Hispanic
City, State Zip	JACKSON • KS • 85109	Phone 458 - 869 - 5236
Provider Info	rmation	
	○ Regular Billing ○ Direct Billing	
Provide	er 🔽	Referring Provider
Serv Name/Addre		V
Form Type/V	ersion	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	pe Fatter History (Green)	
Vers	ion Forms for Services Provided On or After June 30, 2009	Create Form Close
	Forms for Services Provided On or After June 30, 2009	
	Forms for Services Provided On or After June 30, 2008	
	Forms for Services Provided On or After June 30, 2006 Forms for Services Provided On or After June 30, 2005	
	Forms for Services Provided On or After June 30, 2004	

Filling Out a Form

The name is displayed before entering the data. The form on the screen is the same as the paper form. Fill in the form and click the 'Submit' button at the bottom of the screen to submit/save.

To fill in the forms use the mouse, tab key, or the space bar. To use the mouse, click on the drop down arrow and then select the appropriate choice. If using the mouse for buttons, just click inside the circle. All forms work the same way.

If content of the drop down box is known, then tab to the empty field and type the first letter. The word will appear.

Tab to the next field.

When tabbing and encountering a square radio button, hit the space bar to fill it in.

Tabbing to a radio button will automatically fill in the circle when highlighted.

State of Missouri		_
DEPARTMENT OF HEALTH AND SENIOR SERVICES S		HEA
Current Client: BROWN, MARY _ 2322 W WASHINGTON_UNIONVILLE, MO 90210_No Phone Information Fou	nd	
CLIENT PROVIDER FINANCIAL ADMINISTRATIVE Development		
SUBMIT NEW FORMS / BILLING		
Show Instructions		
Patient History		- 64
Provider SAMII Number - 23730993701 - 416 MARKET STREET, ALTON, MO 65606		
A PERSONAL HISTORY		
Name (Last, First, Middle Initial) BROWN, MARY		
Maiden Name		
Date of Birth 8/3/1942 Social Security Number 015-65-55	524	
Medicaid DCN / Medicare Number 01565524		
Ethnicity: NON HISPANIC		
Race: , BLACK		
Marital Status:		
Date Form Received: MWDD/YYYY		
Date of Msit MM/DD/YYYY		
Number of Household Members Household Income (Monthly)		
How did you hear about SMHW?		
(1) Physician (9) Health Fair		
C (2) Clinic C (10) Health Coalition		
C (3) Television C (11) Outreach Worker		
🕖 Done		

HOW TO COMPLETE 'REPORTING ONLY' PROCESS

EXAMPLE: A client who is eligible for SMHW diagnostic services is referred from an outside provider. The client has had a breast or cervical screening/diagnostic that is suspicious for cancer. Cancer diagnosis by a tissue biopsy is unconfirmed.

- Verify client eligibility
- Have client sign SMHW Client Eligibility Agreement form
- Complete green History form
- Enter data into MOHSAIC from green History form

State of Missouri	OF	HEA	ITH AND SENIOR SERVICES
Current Client: ROSES	MER	2V 16	A SYCAMORE IN JEFERSON CITY MO 65109 (555) 222-4444
CLIENT FINA	NCI	AL	
SUBMIT NEW FORMS / BI	LLING	► Þ <u>v</u>	IEW MEDICAID INFORMATION
		Presider	1 (16) Other Location
B. CLINICAL BREAST EXAM RES	ULTS	(louider	Reporting Only
Does client report any breast symptoms?	No	- A	Idditional Information Required if "YES" Selected
CBEWNL	No	- A	dditional Information Required if "NO" Selected
BENIGN FINDING: SUSPICIOUS FOR CANCER (requires additional follow-up)	Fills	(1) B nodularity (2) D solid) (3) B (4) N (5) S usual; pn (6) E also swel	In al 202 (click only one) enign finding (fibrosystic changes, diffuse lumpiness, clearly defined thickening, tendemess or /) iscrete palpable mass (includes masses that may be diffuse, poorly defined thickening, cystic or loody or serous nipple discharge lipple or areola scaliness or erythema kin dimpling, retraction, new nipple inversion, peau d'orange, ulceration; also one breast lower than ominent veins, unilateral; unusual increase in size, unilateral nlarged, tender, fixed, or hard palpable supraclavicular, infraclavicular, or axillary lymph nodes; ling of upper arm
Date of CBE	04/0	1/2008	MM/DD/YYYY
Rescreen Planned (less than 10 months) Diagnostic Work-up Planned	No. Yes	X	
C. MAMMOGRAM RESULTS			E Begoning Unity
Mammogram Provider Facility		Facility	v Name/City
Province Mammodrame		1	
E			Local intranet

SHOW ME HEALTHY WOMEN SCREENING REPORT FORM 'REFERRAL FEE'

If a SMHW provider performs additional breast/cervical procedures, enter the data and check the appropriate visit type.

If no SMHW screening services are provided by a SMHW provider, check the appropriate 'Visit Type' and check the 'Referral Fee' box if requesting the \$20 referral fee. Provider reimbursement is for the referral fee only, not an office visit.

Report any other outside diagnostic procedures completed prior to enrollment on the appropriate diagnostic form as 'Reporting Only' and report SMHW follow-up procedures as usual.

Current Client: ROSES, MERRY 164 SYCAMORE LN JEFFERSON CITY, MO 65103 (555) 222-4444 User: EE CLIENT PINANCIAL YSUBMIT NEW FORMS / BILLING Image: Client Medicald Information Show Instructions Image: Client Medicald Information Show Instructions Ver B Provider SAMI Number - Service 43 601779101 - SHANNON, COUNTY, HEALTH, DEPARTMENT, Address A PERSONAL DATA Image: Client Bigbling Vertiled Name(Last, First, Model Initial ROSES, MERRY Medicald DCN/Medicare Number: 63045833 Annulal Vert Type Client Bigbling Vertiled Image: Client Bigbling Vertiled No Insurance Coverage Dedocrible Mer How did you hear about SMHW? (1) Physician (2) Clinic (1) Physician (2) Clinic (10) Health Coalition (3) Television (11) Dutreach Worker (2) Clinic (4) Radio (12) Relative/Friend (3) Television	State of Missouri DEPARTMEN'T OI	F HEALTH A	ND SENIOR SERVI	CES	SHOW ME H
CLIENT FINANCIAL YSUBMIT NEW FORMS / BILLING >VIEW MEDICAID INFORMATION Show Instructions Show Instructions Streening Report VerB Provider SAMII Number - Services 43601779101	Current Client: ROSES, MER	RRY 164 SYCAMO	RE LN JEFFERSON CITY, MO 6510	9 (555) 222-4444	User: BET
SUBMIT NEW FORMS / BILLING Pylew MEDICAID INFORMATION Show Instructions	CLIENT FINANC	IAL			
Show Instructions Sceening Report Provider SAMII Number - Service Address 43601779101 - SHANNON COUNTY HEALTH DEPARTMENT Address 43601779101 - SHANNON COUNTY HEALTH DEPARTMENT Address 43601779101 - SHANNON COUNTY HEALTH DEPARTMENT Address APERSONAL DATA Name(Last, First, Middle Initial POSES, MERRY Medice Name Date of Bitth 4/16/1946 social Security Number 555-52-5555 Medicaid DON/Medicare Number 53045633 Annual Meit Type Client Eligibility Merited No Insurance Coverage Deductible Mer For of Medicare How did you hear about SMHUP (1) Physician (2) Clinic (10) Health Fair (2) Clinic (11) Dutreach Worker (2) Statis (12) Relative/Friend (3) Television (13) Insurance (4) Radis (13) Insurance (4) Radis (13) Insurance (4) Radis (4) Radis (4) Insurance (4) Radis	SUBMIT NEW FORMS / BILLIN	IG	CAID INFORMATION		
Screening Report VerB Provider SAMII Number - Service Address 43601779101 - SHANNON COUNTY HEALTH DEPARTMENT 119 GREY JONES STREET, EMINENCE, MO 65466 A PERSONAL DATA Name(Last, First, Middle Initial ROSES, MERRY Maiden Name Date of Birth 4/16/1946 Social Security Number 555-52-5555 Medicaid DCN/Medicare Number 53045633 Annual Vest Type Referral Fee Client Bligbility Verified No Insurance Coverage Dedoctible Mer Type of Medicare How did you hear about SMHMO? (1) Physician (4) Relatin (11) Dutreach Worker (2) Clinic (12) Relative/Friend (3) Television (13) Ilouverviby Extension (4) Radio (12) Relative/Friend (5) Printed &d (13) Ilouverviby Extension	Show Instructions				
Provider SAMII Number - Service 43601779101 - SHANNON COUNTY HEALTH DEPARTMENT 19 GREY JONES STREET, EMINENCE, NO 65466 A PERSONAL DATA Name(Last,First, Middle Initial ROSES, MERRY Meiden Name Date of Birth 4/16/1946 social Security Number 555-52-5555 Medicaid DCN/Medicare Number 53045633 Annual Visit Type Referral Fee Client Bigibility Verified No Insurance Coverage Dedoctible Mer Dedoctible Mer How did you hear about SMHW? (1) Physician (2) Health Fair (2) Clinic (10) Health Coalition (3) Television (11) Dutreach Worker (4) Radio (12) Relative/Friend (7) Prinfed Ad (13) Ibiversity Extension	Screening Report				Ver 64
A PERSONAL DATA Name(Last.First, Mddle Initial ROSES, MERRY Maiden Name Date of Birth 4/16/1946 Social Security Number 555-52-5555 Medicaid DCN/Medicare Number 53045633 Annual Visit Type Referral Fee Client Biglibility Verified No Insurance Coverage Dedocrible Mer Type of Medicare How did you hear about SMHW? (1) Physician (9) Health Fair (2) Clinic (10) Health Coalition (3) Television (11) Dutreach Worker (4) Radio (5) Printed Ad (13) Illower/by Evtencion (13) Insurance (13) Illower/by Evtencion (14) Insurance (13) Illower/by Evtencion (14) Insurance (14	Provider SAMII Number - Service Address	43601779101 - 119 GREY JONE	SHANNON COUNTY HEALT S STREET, EMINENCE, M	h department O 65466	1
Name(Last,First, Middle Initial ROSES, MERRY Maiden Name Date of Birth 4/16/1946 Social Security Number 555-52-5555 Medicaid DCNA/Addicare Number 63045633 Annual Visit Type Referral Fee Client Bigblility Verified No Insurance Coverage Dedoctible Mer U Type of Medicare How did you hear about SMHW? (1) Physician (9) Health Fair (2) Clinic (10) Health Coalition (3) Television (11) Dutre ach Worker (4) Radio (5) Printed Ad (13) Illiversity Extension (14) Illiversity Extension (14) Illiversity Extension (15) Printed Ad (15)	A. PERSONAL DATA				
Maiden Name Date of Birth 4/16/1946 Social Security Number 555-52-5555 Medicaid DCN/Medicare Number 53D45633 Annual Visit Type Referral Fee Client Biglibility Verified Dedocrible Mer Dedocrible Mer Type of Medicare How did you hear about SMHW? (1) Physician (3) Television (3) Television (11) Dutreach Worker (4) Radio (7) Prinfed Ad (13) University Extension (3) Level intervente	Name(Last, First, Middle Initial	ROSES, MERRY			
Date of Birth 4/16/1946 Social Security Number 555-52-5555 Medicaid DCN/Medicare Number 53045633 Annual Visit Type Visit Type Client Bigibility Verified No Insurance Coverage Deductible / Mer Image: Type of Medicare Type of Medicare How did you hear about SMHW? (1) Physician (2) Clinic (2) Clinic (10) Health Fair (3) Television (11) Dutreach Worker (4) Radio (12) Relative/Friend (7) Printed Ad (13) Ibiversity Extension	Maiden Name	-			
Annual Visit Type Referral Fee No Insurance Coverage Deductible Met Type of Medicare How did you hear about SMHW? (1) Physician (2) Health Fair (2) Clinic (10) Health Coalition (3) Television (11) Dutreach Worker (4) Radio (12) Relative/Friend (5) Printed 2d (13) University Extension	Date of Birth 4/16/1946	Social Security Number	655-52-5555 Medicaid DC	N/Medicare Number	3045633
Annual Visit Type Referral Fee Client Bigblilty Verified Dedocrible Met Type of Medicare How did you hear about SMHW? (1) Physician (9) Health Fair (2) Clinic (10) Health Coalition (3) Television (11) Dutreach Worker (4) Radio (5) Printed Ad (13) Illiversiby Extension (14) Illiversiby Extension (14) Illiversiby Extension (15) Printed Ad (15) Printe					
No Insurance Coverage Insurance Coverage Image: Type of Medicare How did you hear about SMHN0? (1) Physician (2) Clinic (10) Health Fair (2) Clinic (11) Dutreach Worker (2) Radio (12) Relative/Friend (7) Printed Ad (13) Iniversity Extension	Annual Visit Type	Client Bigibi	Iless Schriftand		
How did you hear about SMHW? How did you hear about SMHW? (1) Physician (2) Health Fair (2) Clinic (10) Health Coalition (3) Television (11) Dutreach Worker (4) Radio (12) Relative/Friend (5) Printed Ad (13) University Extension	No. Therease Course		ary verned		
How did you hear about SMHW/? (1) Physician (2) Clinic (2) Clinic (3) Television (11) Dutreach Worker (4) Radio (5) Printed Ad (13) Ilniversity Extension (13) Ilniversity Extension (14) Ilniversity Extension (15) Printed Ad (15) Printed A	insurance Coverage	Deductible k	oet		
(1) Physician (9) Health Fair (2) Clinic (10) Health Coalition (3) Television (11) Dutreach Worker (4) Radio (12) Relative/Friend (5) Printed Ad (13) Il inversity Evtension	How did you hear about SMHW?		Type of Medicare		
(2) Clinic (10) Health Coalition (3) Television (11) Dutreach Worker (4) Radio (12) Relative/Friend (5) Printed Ad (713) University Extension		C (1) Physician	🦳 (9) Health Fair		
C (3) Television C (11) Dutreach Worker C (4) Radio C (12) Relative/Friend C (5) Printed Ad C (13) University Extension		🤨 (2) Clinic	🤆 (10) Health Coalition		
(4) Radio (12) Relative/Friend (5) Printed &d (13) University Extension		C (3) Television	C (11) Outreach Worker		
C //5) Printed &/ C //13) University Extension		C (4) Radio	C (12) Relative/Friend		
		C (5) Printed Ad	C (13) University Extension		1
					- lintrapot

An error message may appear at the bottom of the screen after the 'Submit' button is clicked. If this happens, the system will require form correction before proceeding. Upon form correction, click the 'Submit' button again and the system will proceed to the next screen.

After the successful submission of the form the 'Submit Form' screen will again be displayed. If you wish to continue with this client for additional forms, return to 'Submit New Form/Billing.'

To search for another client, type over the current name and the new search result screen will appear. Select the new SSN and the screen will refresh with the new client name and information.

DEPARTMENT OF HEALTH AND SENIOR SERVICES	SHOW ME H	EALT
Current Client: BROWN, MARY 2322 WWASHINGTON UNIONVILLE, MO 90210 No Phone Info	ormation Found	_
CLIENT PROVIDER FINANCIAL ADMINISTRATIVE Development	t	
SUBMIT NEW FORMS / BILLING		_
Have you had a hysterectomy?		
If YES, what was the reason for having a hysterectomy?	Clear	
Do you still have a cervix?		
E. TOBACCO USE		
Have you smoked at least 100 cigarettes in your entire life?		
Do you now smoke cigarettes?		
During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?		
	Submit Cancel	
Any Errors Displayed Here Must Be Entered • Date of Visit Must be Entered • Number of Household Members Must be Entered • Household Income Must be Entered • How Heard About SMHW Must be Selected • Highest Grade Completed Must be Selected		
🥭 Done		

SHOW ME HEALTHY WOMEN PATIENT HISTORY FORM (GREEN FORM) SUBMISSION

Green History Form

- The first form that needs to be entered in MOHSAIC with each annual screening.
- Includes Demographic information, Ethnicity, Race, and other needed info. All areas of form need to be filled out.
- SSN is recommended but not required. Having a SSN to enter in MOHSAIC will prevent a duplicate record being created on the same client. SSN is required for Full BCCT Medicaid coverage.
- The item: "Language Spoken in the Home" must be completed
- "Date of Last Mammogram" & "Date of Last Pap" must be completed. An estimated date (month/yr) is fine.

Name, DOB, SSN, DCN, Address, and Phone number auto-populate into form. The rest of the info needs to be completed and then click Submit.

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SHOW ME HEALTHY WOMEN SCREENING FORM (BLUE FORM) SUBMISSION

Blue Screening Form

- Enter Screening visit information from clinical well woman visit notes.
- Select VISIT TYPE:
 - Initial- (CBE & Pelvic done)
 - Annual-(CBE & Pelvic done)
 - Initial CBE only- (CBE only)
 - Annual CBE only- (CBE only)
- BSE- Client breast concerns
- CBE- clinical breast exam. Normal or Abnormal results
- Screening mammogram completed after the clinical breast exam <u>always</u> goes on Blue form.
- 6 month dx mammogram is entered on Blue Form.
- Pelvic exam results entered , if completed.
- PAP results entered, if client eligible for test per SMHW & ASCCP guidelines.
- A 6 month follow up diagnostic mammogram also goes on Blue form.

Blue Screening Form cont.

- Enter Screening visit information from clinical well woman visit notes (cont.)
- Pelvic exam results entered , if completed.
- If Pelvic exam identifies an abnormal finding on the cervix, client may need further follow up with GYN specialist.
- Note if client is Premenopausal or Postmenopausal.
- PAP results entered, if client eligible for test per SMHW & ASCCP guidelines.

Provider name & address, Client name, date of birth, SSN, and DCN auto-populate into form. The rest of the info needs to be completed and then click Submit.

RESULTS:			Reports	Iny
Read Sent report any made by main off	No *	Joánsral (ríomation)	Replaced H ^{ar} vEc ² Selected	
	Yes *	A domina information P	Regimed # 100 Sweden	
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a weatwardney (Rebuilts II	-11-		- Rapping (

Remember: Date of Last Mammogram & PAP need to be entered on this form! UNKNOWN is NOT a good option. If client has abnormal result, Select YES –Dx Work up Planned. Fill in Mon/Yr (follow up needs to be completed within 60 days of Screening exam.

Pelvic section and PAP entered if completed during exam.

E PELVICIENTI PESUCIEI			
Pely o Psem Will Autoord Information Required 7 710 Decemen	Yes *		
+(cantinn)?	No -	Converteent Converteent Dourse Convert Convert costs Annual Papiest Converteent Header Dongelbeeterty Anthretin	
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PIEVOUS PAPITES		Yes *	
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uste of the PAP Test		7/15/2015 NU/DRIVY/Y	

Remember: Date of Last PAP need to be entered on this form! UNKNOWN is NOT a good option. If client has abnormal result, Select YES –Dx Work up Planned. Fill in Mon/Yr (follow up needs to be completed within 60 days of Screening exam). Important: if client has had hysterectomy d/t cervical cancer, client is eligible for annual PAP.

Blue Screening Form cont.

- PAP enter from lab results & note if EC cells are present or not. Abnormal results follow up per ASCCP guidelines.
- **An unsatisfactory PAP specimen is not payable by SMHW. **
- Enter HPV results, if completed.
- COMMENTS- type any additional information from screening CBE/Pelvic exam that may be helpful for SMHW program to be aware of. i.e.: "Reporting only screening mammogram paid by BCFO" or "approved for BCLP fund to pay for screening mammogram" or "Referred to GYN for consult".
- COMMENTS- also type who entered the form, for example "entered by MRice".

Preyous PAR Test	Yes *			
uste of Last High Test	montr 9 year 20	0.14		
Date of This PAP Tes.	7/15/2015	R/BD/YTYY		
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eto vela Arrice. Service General Interne	07/2010			

Blue Screening Form Visit Types Initial Screening



Annual Screening



Initial CBE Only



Annual CBE Only



Rescreen Visit

Screening Form- Visit Types



Screening Form (Blue Form) Reporting Only- Client with Abnormal PAP Referred to SMHW for Colposcopy

ALL LAUDIAL DAIA		
Name(Last,First, Middle	County at TOV:	
Maiden	Name	
Date of Age (Years): 35	f Birth Social Security Number	Medicald DCN/Medicare Number
Data Form Rec	wived: 07/02/2014 MM/DD/YYYY	Initial Visit Type
Yes + Gient Elablity Ve	rified No 🔹 Insurance Coverage	ilenistrie Ver
	Type of Medicar	re
Height Ft	in Weight Ibs. BMI	Bladd Pressure Average / / / 1st Reading 2nd Reading
B. CLINICAL BREAST EXAM RESULTS		Reporting 6
Does client report any breast symptoms?	No - Additional Information Required in	I 'YES' Selected
CBE WNL	Yes - Additional Information Required If	"NO" Selected
BENIGN FINDING:	Findings Present at CBE (check only on Within Normal Limits	e)
suise drouté eoire d'Audée Régulie é protécier (eurren)	① 1) Benign finding (fibrosystic changes, diff	use lumpiness, cleany defined thickening, tenderness or nodularity)
Date of CBE	05/07/2014 MW0D/YYYY	
Rescreen Planned (less than 10 months)	No =	MALTIN
Diagnostic Work-up Planned (must be less than 60 days)	No =	

(2) [4) Mammogram not done. Patient (DR proceeded directly for other imaging	only received CBE or diagnostic workup	(5) Cervical record only,	mammogram not done
🔘 (1) Routine screening memmogram		(8) Referred to Diraci Biller for Mammegram	
 (C) (2) Mammogram performed to evaluate symptoms: Paelove BDE Paelove DDE 		 (3) Abnormal mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation (Enter results in Mammogram field as Reporting Only) Date Client Referred for diagnosis 	
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(5) Breast record only, cervical services not done		(1) Routine Pap test		
		\bigcirc (2) Patient under surveillance for pr	evieus abnormal (Rescreen)	
		 (4) Pap test not done. Patient proce or HPV test 	eeded directly for diagnostic workup	
		(6) Referred to Direct Biller for Pap	and Pelvic	
		(3) Abnormal Pap test done by non	program provider (reporting only)	
		Reterral Date: 05/21	/2014	
E. PELVIC EXAM RESULTS		Reporting Only		D
Pelvic Exam WNL Additional Information Required if "NO" Solected	Yes 🔻			
	Den	(Rosen)		
	Cerval Attentione to Lenvica Lenvier			
Hysterectomy?	Gen A Peer			
	No - Resetter Turniyaeredumiy ovr -			
Date of Pelvic Exam	05/07/2014 MM/DD/YYYY			
Reproductive Status	Premenopausal ① Postmenopausal			
Reported Pantos Vess pren 10 montas	No +	NUMBER		

Previous PAP Test	Yes	•		
Date of Last PAP Test	month 05	year 2013		
Date of This PAP Test	05/07/2014	MM/DD/YY	m	
Specimen Adequacy @ Satisfactory				
Clear Classificationy Di	e To:			
🛈 Linksown				
Specimen Type		al Smear 🤨 Liquid I	lased Clear	
	O Ann	tual Pap due to previ	ous treatment for cerv	rical cancer
SMHW PAP Test Result (Select one)				
NORVA		ive for Intracrithelial	Legion or Nalianapov	
ABNORMA	L () (2) Atvoic	al Squamous Cells o	f Undetermined Signifi	icance (ASC-US) (May have HPV text)
	(a) (3) Lovos	ade SIL (HPV/MM D	solasia/CIN II	and the second second second second
Clear	(4) Atvoic	al Squamous Cells o	annot exclude HSIL (A	45C-H) *
	() (5) Higher	rade SIL (with feature	e suspicious for invas	ion/CIN II-III/CIS) *
	(6) Souar	nous Cell Cancer*		and the street of
	(7) Atypia	sal Glandular Cells (in na) *	oluding atypical endo	cervical adenosarcinoma in SITU and
©7+€	R 💿 (9) Other	1		
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Endoservical Cells HPV Profile: Clear	Yes - 05/07/2014 HPV Test Resul Positive(Hig	MWDDMMM 11 gh Risk) 👻	Peparting Only	
Endoservical Cells HPV Prefile: Clear Rescreen Flanned (less than 10 months)	Yes + 05/07/2014 HPV Test Result Positive(High No +	MWDDMMM 14 gh Risk) 👻	IV Reporting Only	
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Endoservical Cells HPV Profile: Clear Rescreen Flerned (less than 10 months) Diagnostic Work-up Planned (Nust be less than 90 days) Referred for Diagnostic Work-up / Direct Biller Date Next Annual Cervical Cancer Screening:	Yes + 05/07/2014 HPV Test Result Positive(High No + Yes + Physician / Fact	MM/DD/YYYY It gh Risk) + aity Name	 I Reporting Only 06/2014 	MMYYYY
Endoservical Cells HPV Prefile: Clear Rescreen Flanned (less than 10 months) Diagnostic Work-up Planned (Nust be less than 90 days) Referred for Diagnostic Work-up / Direct Biller Date Nakt Annual Carvical Cancer Screening: COMMENTS Maximum length is 788 characters.	Yes • 05/07/2014 HPV Test Resul Positive(His No • Yes • Physician / Faci	MM/DD///// ti gh Risk) + iity Name	 [V] Reporting Only 06/2014 	MMYYYYY
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Screening From (Blue Form) Mammogram Only

Vas viene Na		To enter a Mammogram alone:
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Hagel It Was	Blood Pressure Average	1) Select Visit type: <u>Annual</u> (if
E OLINICAL EREAST EXAM	Jet Reading 2nd Reading	 mammogram follows a SMHW
RESULTS	Reporting	office visit) or Percrean (if
pleast symptoms?	labaranay informanian Requires M "YES" Selected	office visit) of <u>Rescreen</u> (if
	danchel Information Requires # 110" Selected	mammogram is 6 month follow up.
Rescreen Planned lines	NWGENAAA	Complete Client Eligibility Verified 8
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C. SUAMUCORAU RESULTS Cart	Escator	Insurance Coverage drop down
		boxes. Leave the rest of the info (ht
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O Fastove 555	(Emericeults in Mammogram field as Reporting Only)	
O Positive CBE	Date Client Referred for disphasis	3) Go to Section C- Mammogram
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Marrimogram Provide/ Fability	MERCY CH CHUB OREILLY CANCER CENTER	·
Date of Last Mammoran	05 2010	results.
Dars of Trip Varnwogram	4/16/2013	4) Go to Section D- Select (5) Breast
		record only annular learning and
Aller er naulweßlam	O Conventorial O Digital	record only, cervical services not
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	O 8 O Freezely Bangn (Calagoly 2)	5) Skip sections E & F
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Hammogram Result Comme		Status (Section F) to get the form to
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Diegnostic Work-up Planned Must de less than 50 carys)	Ne -	submit. Otherwise
Referred for Diagnostic Teacing / Direct Biller	Enysiosi (Esoin) kons	Scroll to bottom of the blue form
Servicel Cancer Screening Class	and a second	and enter any Comments needed
(8) Erest record only, cervical servi	ses not some 01 Poutine Pagiter:	and enter any <u>comments</u> needed.
	(2) (2) Patient Linder surveillance for brevious abnormal /Respress).	8) Hit the Submit button.
	 (e) Pac test not zone. Patient proceeded directly for olignosisc workup pr HPV test 	
	O (d) Referred to Direct Biller for Fas and Pelvis	
	CI/81 Abnomial Papitati done by non program provider iredoning only)	
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	Cose WW form for same clant after subert	

SHOW ME HEALTHY WOMEN BREAST FORM (PURPLE FORM) SUBMISSION

Provider name & address, Client name, date of **Purple Breast Form** birth, SSN, and DCN auto-populate into form. The rest of the info needs to be completed and then Diagnostic mammogram after click Submit. abnormal CBE or follow up to BIRAD 0 screening mammogram is entered on this form. Gorvenora Supra Clear Ultrasound results entered Biopsy results entered, if applicable. (most of the time, Criczy 1 (*) Wassive Golappy 2 (*) Service Testing Category 5 (0) S (*) Category 5 biopsy paid by BCCT & entered as "Reporting only"). • Final Dx/Work up Complete a 🔞 al ŝusu ciula Kohomanty (Cales entered, or If Dx work up not completed-Lost to Follow up entered. ** Need specific contact attempt dates/type.** RPC must be () Limer notified after at least 2 attempts to (ē) Limitas contact client are unsuccessful. . Treatment start date, type, treatment facility entered if client diagnosed with Breast Cancer.

Date of BIRAD 4 or 5 US to Date of Bx must be less than 60 days. If diagnosed with breast cancer, client should also start treatment within 60 days of biopsy date.

MMED/IT IT

3 G. Pressoy Burger (Company C)

a () Stemmer Anomality (Delegor) 4 - Selects 8/31

Enter any info regarding BCCT submissions and dx/tx follow up scheduled in COMMENTS.

SHOW ME HEALTHY WOMEN CERVICAL FORM (YELLOW FORM) SUBMISSION

Yellow Cervical Form

- GYN Specialist Consult may be completed for abnormal Pelvic exam results noted at screening exam.
- Colpscopy entered for abnormal PAP results (follow ASCCP guidelines)
- Polypectomy|(Cervical biopsy) entered for removing suspicious cervical polyp.
- Final Dx/Work up Complete entered & Final Dx date, or
- If Dx work up not completed-Lost to Follow up entered. ** Need specific contact attempt dates/type.** RPC must be notified after at least 2 attempts to contact client are unsuccessful.
- Treatment start date, type, treatment facility entered if client diagnosed with CIN2, CIN3 or Invasive Cervical Cancer.

Specialist Consultation		MM/DD/YYYY	Reporting Only	
Diagnostic Work-up Planned	🔿 None 🔿 O	- 60 Days 🔘 61 - 90 Days		
Colposcopy without Biopsy		MM/DD/YYYY	Reporting Only	
Colpescopy	8/12/2015	MM/DD/YYYY	Reporting Only	
Polypectomy		MM/DD/YYYY	Reporting Only	
Cervical Biopsy Colposcopy inadequate, need further diagnostic Cervical Biopsy Endocervical Biopsy Can only be reimbursed with cervical biopsy Cervical Biopsy Can only be reimbursed with cervical biopsy				
LEEP or Cold Knife done for DIAGNOSTIC purposes				

requires Prior Authorization from SMHW- Contact your RPC. LEEP/Cold Knife are typically Treatment after Colposcopy Dx of CIN2,3 results.

Final Diagnosis Date 8/12/2015 MMIDD/YYYY (includes lost to follow-up, refused, and irreconcilable)

	Province Harrow Marca 194 - 19
Diagnos	nd results with (*) require treatment
D. CERV	ICAL TREATMENT
	tus of Treatment O Started
	O Pending
	O Last to F/U (Describe in comment section)
	Refused (Describe in comment section/Must have signed waiver)
	No: Needed
	Clear
	Types O cryotherapy
	Redistion Therapy

If client has biopsy pathology dx of CIN2, CIN3 or Invasive Cervical Cancer- submit BCCT app. Client should also start treatment within 60 days of colposcopy/polypectomy biopsy date. Enter any info regarding BCCT submissions and dx/tx follow up scheduled in COMMENTS.