



Service Detail Form

Client ID: _____

Admission ID: _____

Client's name (first, middle, last) _____ Maiden name _____

Birth date ____/____/____ Social Security # _____ Medicaid ID # _____

County of service: _____

Primary Payment Source (Medical):

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> county funds | <input type="checkbox"/> Medipass | <input type="checkbox"/> SSI | <input type="checkbox"/> other specify _____ |
| <input type="checkbox"/> eligible/not receiving Title XIX | <input type="checkbox"/> OB indigent | <input type="checkbox"/> Title V | |
| <input type="checkbox"/> HawkI | <input type="checkbox"/> presumptive eligibility | <input type="checkbox"/> uninsured | |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> private insurance | <input type="checkbox"/> unknown | |
| <input type="checkbox"/> Medicaid/Title XIX | <input type="checkbox"/> self-pay/sliding scale | <input type="checkbox"/> non-billable | |

Primary Payment Source (Dental):

- | | | |
|---|---|--|
| <input type="checkbox"/> Hawk-i | <input type="checkbox"/> presumptive eligibility | <input type="checkbox"/> Title V |
| <input type="checkbox"/> I Smile | <input type="checkbox"/> private dental insurance | <input type="checkbox"/> other specify _____ |
| <input type="checkbox"/> Medicaid/Title XIX | <input type="checkbox"/> self-pay/sliding scale | |

Enter services and time below. More than one service may be entered for a date. Services are listed by service category in the chart on the next page.

Date	Service (see list)	Interaction Type (1) home visit (2) agency/clinic visit (3) oral health visit (4) phone	Time In	Time Out	Other Planned Interventions or Comments ● List information/concerns shared with family ● If Care Coordination -indicate <u>place</u> , <u>nature of service</u> and <u>service provided by</u>
					<input type="checkbox"/> Initial or periodic dental evaluation (page 2) <input type="checkbox"/> Care Coordination <input type="checkbox"/> See client chart for documentation of service
					<input type="checkbox"/> Initial or periodic dental evaluation (page 2) <input type="checkbox"/> Care Coordination <input type="checkbox"/> See client chart for documentation of service
					<input type="checkbox"/> Initial or periodic dental evaluation (page 2) <input type="checkbox"/> Care Coordination <input type="checkbox"/> See client chart for documentation of service
					<input type="checkbox"/> Initial or periodic dental evaluation (page 2) <input type="checkbox"/> Care Coordination <input type="checkbox"/> See client chart for documentation of service
					<input type="checkbox"/> Initial or periodic dental evaluation (page 2) <input type="checkbox"/> Care Coordination <input type="checkbox"/> See client chart for documentation of service
					<input type="checkbox"/> Initial or periodic dental evaluation (page 2) <input type="checkbox"/> Care Coordination <input type="checkbox"/> See client chart for documentation of service

<p>If Initial or periodic dental evaluation Date: Was decay present (obvious or suspicious)? <input type="checkbox"/> yes <input type="checkbox"/> no Restored teeth (fillings or crowns) present? <input type="checkbox"/> yes <input type="checkbox"/> no Gingivitis (gum bleeding/swelling/pain)? <input type="checkbox"/> yes <input type="checkbox"/> no Oral health risk level: <input type="checkbox"/> low <input type="checkbox"/> moderate <input type="checkbox"/> high Name of dentist referred to: _____ What is client's referral need? <input type="checkbox"/> immediate <input type="checkbox"/> 3mo <input type="checkbox"/> 6mo <input type="checkbox"/> 12mo Notes:</p>	<p>If Initial or periodic dental evaluation Date: Was decay present (obvious or suspicious)? <input type="checkbox"/> yes <input type="checkbox"/> no Restored teeth (fillings or crowns) present? <input type="checkbox"/> yes <input type="checkbox"/> no Gingivitis (gum bleeding/swelling/pain)? <input type="checkbox"/> yes <input type="checkbox"/> no Oral health risk level: <input type="checkbox"/> low <input type="checkbox"/> moderate <input type="checkbox"/> high Name of dentist referred to: _____ What is client's referral need? <input type="checkbox"/> immediate <input type="checkbox"/> 3mo <input type="checkbox"/> 6mo <input type="checkbox"/> 12mo Notes:</p>
---	---

Shaded services below require input of time in and time out.

Service Category	Code	Service
Oral Health Services	D0150	Initial screening evaluation
	D0120	Periodic screening evaluation
	D0270	Bitewing radiograph-single film
	D0272	Bitewing radiograph-two films
	D0274	Bitewing radiograph-four films
	D1110	Prophlaxis-adult (age 13 and older)
	D1120	Prophlaxis-child (age 12 and under)
	D1206	Topical fluoride varnish (therapeutic app for moderate to high decay risks)
	D1310	Nutritional counseling (for the control and prevention of oral disease)
	D1320	Tobacco counseling (for the control and prevention of oral disease)
	D1330	Oral hygiene instruction (hands-on demonstration)
D1351	Sealant-per tooth (primary and permanent molars, premolars)	
Injection	90471	Administration fee for immunizations only
	90633	Hepatitis A pediatric /adolescent - 2 dose
	90649	Human Papilloma Virus - HPV
	90658	Influenza virus vaccine, age 3 years and older
	90707	Measles, mumps and rubella virus vaccine
	90710	Measles, mumps and rubella varicella (MMRV)
	90714	Tetanus,diphtheria toxoids (TD) 7 years and older preservative free
	90715	Tetanus,diphtheria toxoids and acellular pertussis
	90716	Varicella vaccine
	90718	Tetanus,diphtheria toxoids absorbed (TD) 7 years and older
	90734	Meningococcal conjugated vaccine
	90743	Hepatitis B vaccine; adolescent (two doses)
	90744	Hepatitis B vaccine; pediatric/adolescent (three doses)
	90746	Hepatitis B vaccine; adult, 20 or older
	90782	Injection of medication
	90472	Administration oral or nasal
J2790	Rhogam, RHO D Immune Globulin, Human INE	
Care Coordination	H1002	Care Coordination
	T1016	Dental care coordination
	99999	Service Addendum
Health Education Services	H1003	Health Education

Service Category	Code	Service
Social Work Services	H0046	Mental health services
Maternity Care	99201	Self limited or minor approx 10 min.
	99202	Straight forward low to mod. severity- 20 min
	99203	Low complexity to mod severity 30 min
	99204	Mod to high severity - 45min.
	99205	High complexity, mod to high severity - 60 min
	99211	Minimal problems 5 min
	99212	Self limited or minor approx 10 min.
	99213	Low to mod complexity- 15 min
	99214	Mod to high complexity - 25 min
	99215	Mod to high complexity - 40 min
	59425	Antepartum care only, 4 - 6 visits
59426	Antepartum care only, 7 or more visits	
59430	Postpartum care only (separate procedure)	
59025	Non Stress Test	
81025	Urine Pregnancy Test, by Visual Color Co	
T1001	Nursing Assessment	
Nutrition Services	S9465	Diabetes services
	S9470	Nutrition counseling dietitian
Home Visit	S9123	Nursing visit in the home
	S9127	Social work visit in home
Local Transportation	A0080	Non -emergency transportation vehicle provided by
	A0100	Non-emergency transportation - taxi
	A0110	Non - emergency transportation - bus
	A0130	Non - emergency transportation - wheelchair van
	A0160	Non- emergency transportation - caseworker/social
	A0170	Transportation - parking fee, tolls other
Maternity Services	99420	Medicaid prenatal risk assessment
Outreach	12345	Presumptive Eligibility Determination
Translator	T1013	Sign language or oral interpreter
	W5023	Telephonic oral interpreter