Supplemental Information Fax Back Form

Provider Name:
Group:
TIN:

Member MID:
Member Name:
Member DOB:
We have evidence of the following services:

☐ **AAP** Adults' Access to Preventive/ Ambulatory Health Services	☐ **EED** Eye Exam for Patients with Diabetes
☐ **BCS-E** Breast Cancer Screening	☐ **GSD** Glycemic Status Assessment for Patients with Diabetes
☐ **BPD-E** Blood Pressure Control for Patients with Diabetes	☐ **IMA-E** Immunizations for Adolescents
☐ **CBP** Controlling High Blood Pressure	☐ **KED** Kidney Health Evaluation for Patients with Diabetes
☐ **CCS-E** Cervical Cancer Screening	☐ **LSC-E** Lead Screening in Children
☐ **CHL** Chlamydia Screening	☐ **PPC** Prenatal & Postpartum Care
☐ **CIS-E** Childhood Immunization Status	☐ **W30** Well-Child Visits in the First 30 Months of Life
☐ **COA** Care for Older Adults	☐ **WCC** Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents
☐ **COL-E** Colorectal Cancer Screening	☐ **WCV** Child & Adolescent Well-Care Visits

Behavioral Health Services:

☐ **ADD-E** Follow-up Care of Children Prescribed ADHD Medication (Initiation) ☐ **ADD-E** Follow-up Care of Children Prescribed ADHD Medication (Maintenance)	☐ **FUM** Follow-Up After Emergency Department Visit for Mental Illness
☐ **DSF-E** Depression Screening and Follow Up for Adolescents	☐ **IET** Initiation and Engagement of Substance Use Disorder Treatment (Initiation) ☐ **IET** Initiation and Engagement of Substance Use Disorder Treatment (Engagement)
☐ **FUH** Follow-Up After Hospitalization for Mental Illness	☐ **PDSE-E** Postpartum Depression Screening and Follow Up (Screening) ☐ **PDSE-E** Postpartum Depression Screening and Follow Up (Follow Up)
☐ **FUI** Follow-Up After High Intensity Care for Substance Use Disorder	

Please fax your completed form along with the medical record or lab report to MHS Quality Improvement at #1-866-912-4254.

Office Contact Name:
Office Contact Email:
Office Contact Phone: