



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



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# MOHSAIC

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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

### MOHSAIC LOCATION AND SOFTWARE REQUIREMENTS

The MOHSAIC application is located on MDHSS Portal at:

<http://webapp01.dhss.mo.gov/SMHW/Default.aspx> or  
<https://webapp02.dhss.mo.gov/SMHW/Default.aspx>

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.

### CREATING AUTOMATED SECURITY ACCESS PROCESSING (A.S.A.P) USER PROFILE

**\*\*This step is to be completed only once per user.\*\***


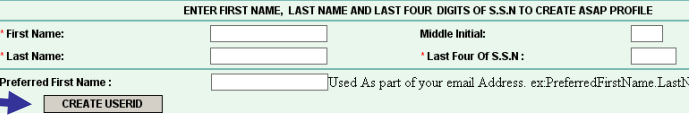
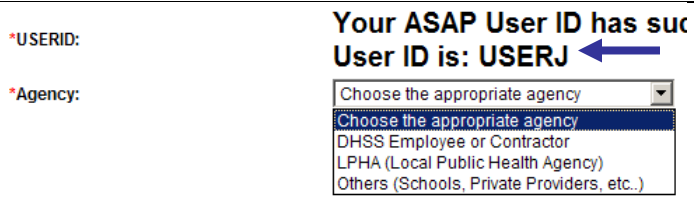
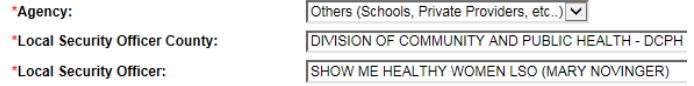
If you have an ASAP profile already and you know your login credentials, please skip to Step 2 (submitting the request).


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 Browsers and enter address  
[http://webapp02.dhss.mo.gov/asap\\_web/ASAPLogin.aspx](http://webapp02.dhss.mo.gov/asap_web/ASAPLogin.aspx)
- Click 'Yes' to any security messages

Steps	Screen Print
<p>1. Click the NEW USER option</p>	
<p>2. 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.</p>	
<p>3. Make note of your UserID.</p>	
<p>3. Choose 'Others (Schools, Private Providers, etc.)' for the Agency.</p> <p>4. Choose 'DHSS DIVISION OF COMMUNITY HEALTH' for Local Security Officer County.</p> <p>5. Choose 'SHOW ME HEALTHY WOMEN LSO – (Sandy Hentges)' for Local Security Officer.</p>	

<p>6. Type your work street number; it will provide a drop-down list. Click your address</p>	<div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center; margin: 0;"><b>ADDRESS INFORMATION</b></p> <hr/> <p>*Address Search (Type in your address starting with Street Number) <input style="width: 150px;" type="text"/> <span style="float: right;">▼</span></p> </div>
<p>7. Enter your e-mail address, telephone number, and fax number</p>	<div style="border: 1px solid black; padding: 5px;"> <p>*Email1 <input style="width: 150px;" type="text"/></p> <p>*Phone1 <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> Ext <input style="width: 30px;" type="text"/></p> <p>Fax Number <input style="width: 80px;" type="text"/></p> </div>
<p>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</p> <p><b>**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.**</b></p>	<div style="border: 1px solid black; padding: 5px;"> <p>* Password <input style="width: 80px;" type="text"/> [Password length between 6-8 ]</p> <p>* Retype Password <input style="width: 80px;" type="text"/></p> <p>* Challenge Question <input style="width: 80px;" type="text"/> ex:What is your favorite color?</p> <p>* Challenge Response <input style="width: 80px;" type="text"/> ex:Blue</p> <p>* Retype Response <input style="width: 80px;" type="text"/></p> </div>
<p>9. Click the CREATE PROFILE button</p>	<div style="border: 1px solid black; padding: 5px; text-align: center;"> <p><b>CREATE PROFILE</b></p> </div>
<p>10. You should see a message about the profile being successfully created. Make note of your User ID</p>	<p>PROFILE SUCCESSFULLY CREATED.          Your ASAP User ID has successfully been generated. Your User ID is: USERL</p> <div style="text-align: right;">    <input style="border: 1px solid black; padding: 2px 10px;" type="button" value="Request Access"/> </div>

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

## REQUEST SMHW ACCESS

- Open Internet Browser and enter address  
[http://webapp02.dhss.mo.gov/asap\\_web/ASAPLogin.aspx](http://webapp02.dhss.mo.gov/asap_web/ASAPLogin.aspx)
- Click 'Yes' to any security messages

<ol style="list-style-type: none"> <li>1. Type the <b>User ID</b> and <b>Password</b> you created in Step A.</li> <li>2. Click the <b>SIGN IN</b> button.</li> </ol> <p><b>**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.**</b></p>	
<ol style="list-style-type: none"> <li>3. Choose the 'Completing for Self' option.</li> <li>4. Click the <b>NEXT</b> button.</li> </ol>	
<ol style="list-style-type: none"> <li>5. Choose '<b>HEALTH APPLICATIONS</b>' for Area Type.</li> <li>6. Choose '<b>SHOWMEHEALTHYWOMEN</b>' for Health Area Type.</li> <li>7. Choose '<b>ADD ACCESS</b>' for Request Type.</li> <li>8. Choose appropriate role from the Role drop down list.</li> </ol> <p><b>*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).</b></p> <ol style="list-style-type: none"> <li>9. Choose appropriate role from the Other Role/Report Type dropdown list. <b>Choose SMHWPROVIDER (****For Use By SMHW Provider) ONLY.</b></li> <li>10. <b>Optional:</b> Type in any comments</li> <li>11. Type in the Effective Date</li> </ol>	

<p>12. If not entering data for additional Providers, leave defaulted to 'NO'.</p> <p>13. To select other Providers, select 'YES' and pick the county and the agency from the the dropdown list</p>	<p>Do you enter Data for Additional Agencies? <input checked="" type="radio"/> YES <input type="radio"/> NO</p> <p>To pick additional Agencies ,Choose the respective County</p> <p>*County: ADAIR - 001</p> <p>*Agency: ADAIR COUNTY HEALTH DEPARTMENT</p> <table border="1"> <thead> <tr> <th>ADD</th> <th>ADDRESS</th> <th>City</th> <th>State</th> <th>Zip</th> </tr> </thead> <tbody> <tr> <td><input checked="" type="checkbox"/></td> <td>1001 S JAMISON</td> <td>KIRKSVILLE</td> <td>MO</td> <td>635010000</td> </tr> </tbody> </table>	ADD	ADDRESS	City	State	Zip	<input checked="" type="checkbox"/>	1001 S JAMISON	KIRKSVILLE	MO	635010000
ADD	ADDRESS	City	State	Zip							
<input checked="" type="checkbox"/>	1001 S JAMISON	KIRKSVILLE	MO	635010000							
<p>14. Click the '<b>I Agree</b>' button.</p> <p>15. Click the '<b>Submit Form</b>' button.</p>	<p>I, THE UNDERSIGNED, AN EMPLOYEE OF THE STATE OF MISSOURI OR AUTHORIZED U UNDERSTAND THAT APPROVAL AND ASSIGNMENT OF THE REQUESTED ID OR APPROV ENABLES ME TO ACCESS THE RESOURCES WHICH, BY LAW, MUST BE UTILIZES ONLY ASSIGNED DUTIES. THEREFORE, I AGREE TO MAKE NO INQUIRIES OR UPDATES WHICI PERFORMANCE OF MY OFFICIAL DUTIES. I UNDERSTAND THAT STATE AND FEDERAL S CONFIDENTIALITY OF INFORMATION AND PROVIDE PENALTIES FOR UNAUTHORIZED A OF INFORMATION. VIOLATIONS OR DISCLOSURES ON MY PART MAY RESULT IN DISCIPL ONE OR ALL OF THE FOLLOWING: (1) SUSPENSION, (2) CIVIL COURT AND (3) DISMISS. CONFIDENTIAL ALL INFORMATION MADE AVAILABLE TO ME IN THE PERFORMANCE OF ADDITION, I AGREE NOT TO DIVULGE OR SHARE MY PASSWORD WITH ANYONE.</p> <p><input type="button" value="Submit Form"/> <input type="button" value="I Agree"/> <input type="button" value="Quit"/></p>										
<p>A message should appear stating the request was successfully completed.</p> <p>Print a copy of the completed form for agency records.</p>	<p>You have successfully completed your request form.Press the button below to view a printer friendly copy of your request for your records. Please do not send the print copy for Request process.</p> <p><input type="button" value="Printer Friendly Copy"/> <input type="button" value="FILL OUT ANOTHER ACCESS FORM"/></p>										

**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.

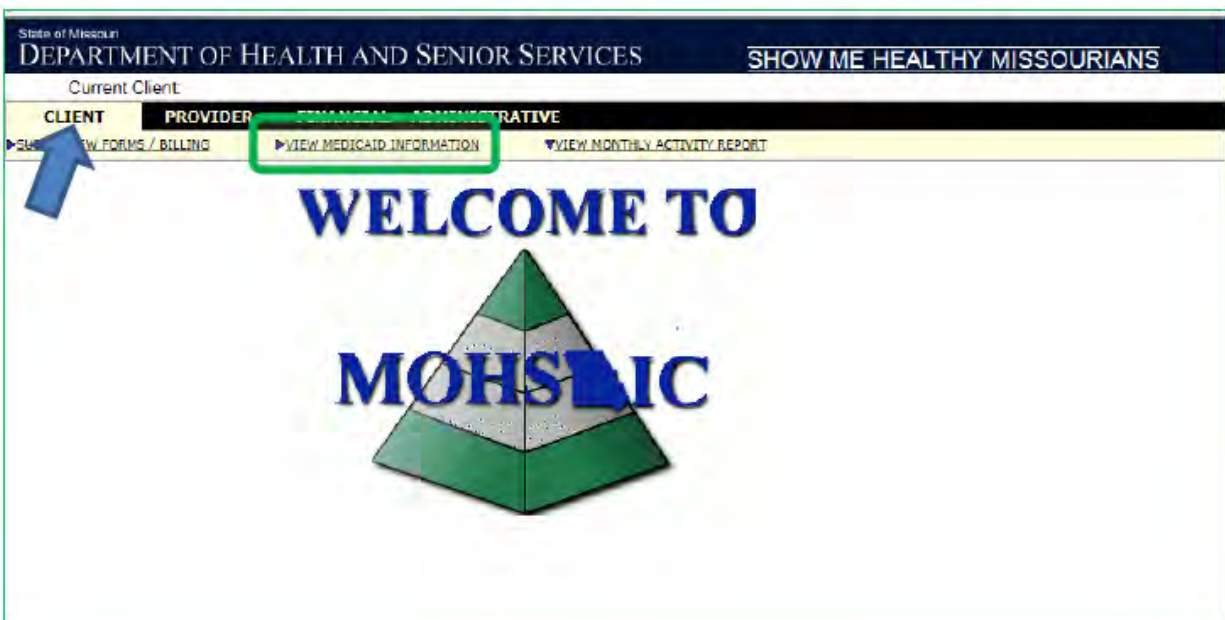
Once logged in, your agency name will appear and stay constant throughout the application. Click the 'Login' button to proceed.





### 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**:



3) Click on Change Client:

State of Missouri  
DEPARTMENT OF HEALTH AND SENIOR SERVICES SHOW ME HEALTHY MISSOURIANS

CLIENT PROVIDER FINANCIAL ADMINISTRATIVE

SUBMIT NEW FORMS / BILLING VIEW MEDICAID INFORMATION VIEW MONTHLY ACTIVITY REPORT

Client Name: Client - None Selected Client DCN:

[Change Client](#)

Client's Medicaid Status	
Status	Status Date

Medicaid Case Information			
Case DCN	Status		
Telephone			
Address 1			
Address 2			
City	State	Zip	
Worker Name			
Worker Phone			
Spend Down Amt			

Client's Medicaid Dates				
Begin Date	End Date	Program	Level Of Care	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.

State of Missouri  
DEPARTMENT OF HEALTH AND SENIOR SERVICES SHOW ME HEALTHY MISSOURIANS

CLIENT PROVIDER FINANCIAL ADMINISTRATIVE

SUBMIT NEW FORMS / BILLING VIEW MEDICAID INFORMATION VIEW MONTHLY ACTIVITY REPORT

Client Name:

Medicaid Data Managed CS

[Change Data refresh](#)

Client's Medi Status

Medicaid Cas Case DCN Telephone Address 1 Address 2 City Worker Name Worker Phone Spend Down A

Client's Medi Begin Date 4/1/2016 7/1/2016

MO Zip

Level Of Care

Client Search - Webpage Dialog

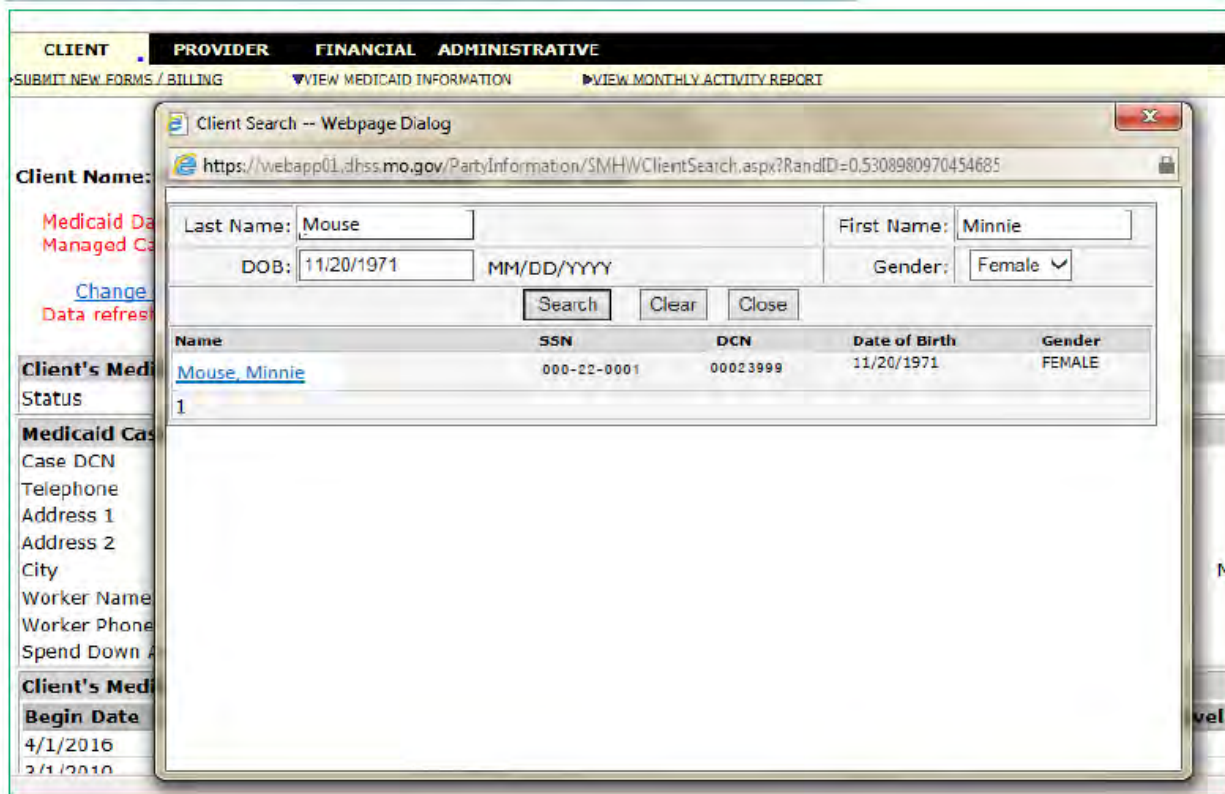
https://webapp01.dhs.mo.gov/PartyInformation/SMHWCClientSearch.aspx?RandID=0.5308380970454615

Last Name: Mouse First Name: Minnie

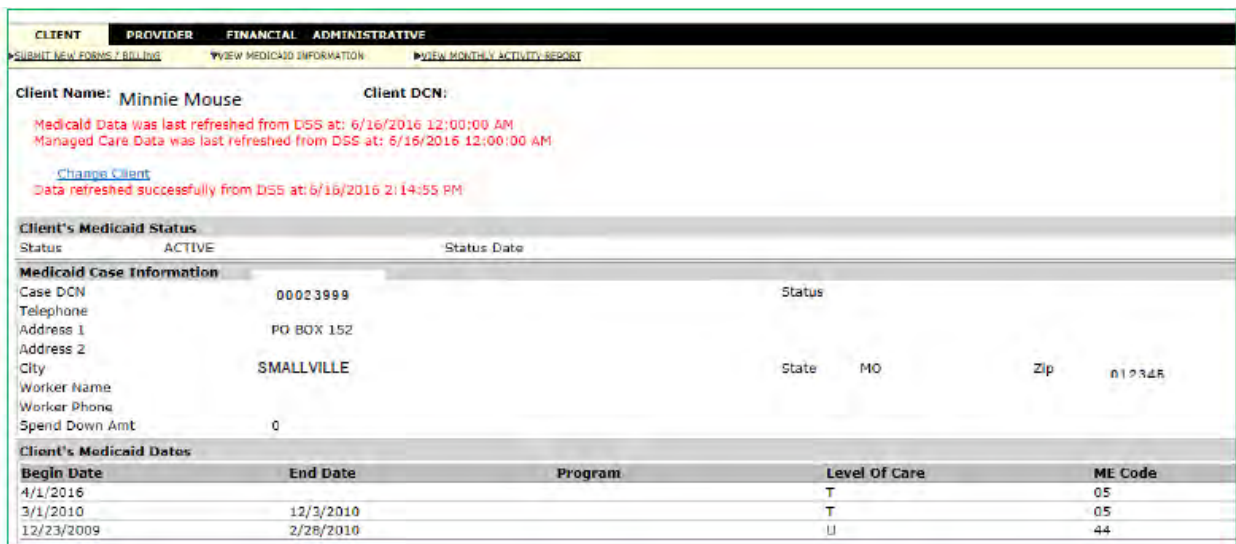
DOB: 11/20/1971 MM/DD/YYYY Gender: Female

Search Clear Close

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.



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.



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 Client: LINDSAY, JENNIFER 27066 OLYMPIC DR LEBANON, MO 65536-4995 County: LACLEDE (417) 718-0979

**CLIENT PROVIDER FINANCIAL ADMINISTRATIVE**

▼ SUBMIT NEW FORMS / BILLING ► VIEW MEDICAID INFORMATION ► VIEW MONTHLY ACTIVITY REPORT

Show Instructions

### Submit Form

**Client Information** -- Please verify address and demographics below and update as needed.

Client Name / SSN	LINDSAY, JENNIFER	?	<a href="#">View/Edit Client Information</a>
Address	27066 OLYMPIC DR	SSN	123-445-6789
		Sex	FEMALE
		DOB	3/15/1975
		Race	WHITE
		DCN	99987654
		Ethnicity	NON HISPANIC
City, State Zip	LEBANON, MO 65536-4995	Phone	417 - 718 - 0979
			<input type="checkbox"/> No Phone

**Provider Information**

Regular Billing  Direct Billing

Provider: [Dropdown] Referring Provider: [Dropdown]

Service Name/Address: [Dropdown]

**Form Type/Version**

Type: [Dropdown] Version: [Dropdown]

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

State of Missouri  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** [SHOW ME H](#)

Current Client: LINDSAY, JENNIFER 27066 OLYMPIC DR LEBANON, MO 65536-4995 County: LACLEDE (417) 71

**CLIENT PROVIDER FINANCIAL ADMINISTRATIVE**

[SUBMIT NEW FORMS / BILLING](#) [VIEW MEDICAID INFORMATION](#) [VIEW MONTHLY ACTIVITY REPORT](#)

---

**View Basic Demographic Information** Required fields are denoted by \*

NAME ID	NAME TYPE	PRIMARY	PREFIX	FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX
<a href="#">EDIT</a> <a href="#">DELETE</a> 1476343057	PRINCIPAL	YES		JENNIFER		LINDSAY	

Add Party Name

SEX\*  DATE OF BIRTH\*  DATE OF DEATH

DEPARTMENT CLIENT NUMBER (DCN)  
98987626

PRIMARY LANGUAGE \*

---

**SPECIAL ASSISTANCE**

Reason	Type
<input type="text"/>	<input type="text"/>

[EDIT](#) [CLOSE](#)

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

**Edit Basic Demographic Information** Required fields are denoted by \*

NAME ID	NAME TYPE	PRIMARY	PREFIX	FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX
<a href="#">EDIT</a> <a href="#">DELETE</a> 1476343057	PRINCIPAL	YES		JENNIFER		LINDSAY	

[Add Party Name](#)

SEX\*  DATE OF BIRTH\*  DATE OF DEATH

DEPARTMENT CLIENT NUMBER (DCN)

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 Demographic Information** Required fields are denoted by \*

NAME ID	NAME TYPE	PRIMARY	PREFIX	FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX
<a href="#">EDIT</a> <a href="#">DELETE</a> 1476343057	PRINCIPAL	YES		JENNIFER		LINDSAY	

[Add Party Name](#)

SEX\*  DATE OF BIRTH\*  DATE OF DEATH

DEPARTMENT CLIENT NUMBER (DCN)

PRIMARY LANGUAGE \*  **Client Information**

SECONDARY LANGUAGE

Reads Primary Language  UNH

Writes Primary Language  UNH

Race \*

**Client Information**

Name Type:  Primary:

Prefix:

Last Name:  First Name:

Middle Name:

Suffix:

[Apply Changes](#) | [Cancel](#)

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**”.

**View Basic Demographic Information** Required fields are denoted by \*

NAME ID	NAME TYPE	PRIMARY	PREFIX	FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX
<a href="#">EDIT</a> <a href="#">DELETE</a> 117196522165	PRINCIPAL	YES		JENNIFER		SMITH	
<a href="#">EDIT</a> <a href="#">DELETE</a> 117077840530	A.K.A.	NO		JENNIFER		LINDSAY	

[Add Party Name](#)

[SAVE](#) [CANCEL](#)

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 FORMS / BILLING](#)  
 [VIEW MEDICAID INFORMATION](#)  
 [VIEW MONTHLY ACTIVITY REPORT](#)

[Show Instructions](#)

**Submit Form**

**Client Information** -- Please verify address and demographics below and update as needed.

Client Name / SSN: <input type="text" value="SMITH, JENNIFER"/> ?	<a href="#">View/Edit Client Information</a>
Address: <input type="text" value="27068 OLYMPIC DR"/> <input type="text"/>	SSN: <input type="text" value="123-445-6789"/> Sex: FEMALE DOB: <input type="text" value="3/15/1975"/> Race: WHITE DCN: <input type="text" value="99987678"/> Ethnicity: NON HISPANIC
City, State, Zip: <input type="text" value="LEBANON"/> , <input type="text" value="MO"/> <input type="text" value="65636-4995"/>	Phone: <input type="text" value="417"/> - <input type="text" value="532"/> - <input type="text" value="5797"/> <input type="checkbox"/> No Phone

**Provider Information**

Regular Billing     Direct Billing

Provider:     Referring Provider:   
 Service Name/Address:

**Form Type/Version**

Type:     Version:

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.

State of Missouri  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** **SHOW ME HEALTHY MISSOURI**

CLIENT FINANCIAL  
▼ DAILY SUMMARY OF FORMS SUBMITTED ► REVIEW PAY STATUS OF FORMS ► PROVIDER CONTRACT INFORMATION

[Show Instructions](#)

Summary of Forms

Provider Name: SHANNON COUNTY HEALTH DEPARTMENT [Close]

April 2008

Select a Highlighted Date to Display Forms for this Provider for the Selected Date

Sun	Mon	Tue	Wed	Thu	Fri	Sat
30	31	1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	1	2	3
4	5	6	7	8	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  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** SHOW ME HEALTHY MISSOURI

**CLIENT** **FINANCIAL**

[DAILY SUMMARY OF FORMS SUBMITTED](#) [REVIEW PAY STATUS OF FORMS](#) [PROVIDER CONTRACT INFORMATION](#)

[Show Instructions](#)

Pay Status of Forms

Provider Name:	SHANNON COUNTY HEALTH DEPARTMENT	
Client Name:	Last:	First:
Form Status:	<input checked="" type="checkbox"/> Submitted By Provider	<input checked="" type="checkbox"/> Approved
<a href="#">Uncheck All</a>	<input checked="" type="checkbox"/> Released To Finance For Payment	<input checked="" type="checkbox"/> Check Mailed
Visit Date Range:	Begin Date:	End 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  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** **SHOW ME HEALTHY MISSOURI**

**CLIENT**      **FINANCIAL**

[▶ DAILY SUMMARY OF FORMS SUBMITTED](#)    [▼ REVIEW PAY STATUS OF FORMS](#)    [▶ PROVIDER CONTRACT INFORMATION](#)

Provider Name:	SHANNON COUNTY HEALTH DEPARTMENT	
Client Name:	Last: <input type="text"/>	First: <input type="text"/>
Form Status:	<input checked="" type="checkbox"/> Submitted By Provider <a href="#">Uncheck All</a>	<input checked="" type="checkbox"/> Approved <input checked="" type="checkbox"/> Check Mailed
Visit Date Range:	Begin Date: <input type="text"/>	End Date: <input type="text"/>

Client Name at Time of Visit	Visit Date	Form Type	Amt Billed	Original Amt Paid	Adjustment	Total Amt Paid	Status	Warrant Date
ROSES, MERRY	04/16/2008	Screening	\$0.00		\$0.00	\$0.00	SUBMITTED BY PROVIDER	

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  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** **SHOW ME HEALTHY MISSOURIA**  
User: BET

**CLIENT**    **FINANCIAL**    **PROVIDER CONTRACT INFORMATION**

▶ DAILY SUMMARY OF FORMS SUBMITTED    ▼ REVIEW PAY STATUS OF FORMS    ▶ PROVIDER CONTRACT INFORMATION

[Show Instructions](#)

**CLAIM DETAILS**

Client Name :	ROSES,MERRY	Form Type :	SCREENING
Visit Date :	4/16/2008	Visit Type :	Initial
Begin Date :	4/16/2008	End Date :	4/16/2008
Total Amount Billed :	\$0.00	Total Amount Paid :	\$0.00

**SERVICE DETAILS**

Service Type	Fund for Payment	<a href="#">Amount Billed</a>	<a href="#">Amount Paid</a>	Diagnosis
OFFICE OUTPT NEW 30 MIN		\$0.00	\$0.00	
		Total Amount Billed on Services: \$0.00    Total Amount Paid on Services: \$0.00		

[Close](#)

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Done Local 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](mailto:support@health.mo.gov).

# SHOW ME HEALTHY WOMEN FORMS AND FORM ENTRY IN MOHSAIC

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## **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 DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 BUREAU OF CANCER AND CHRONIC DISEASE CONTROL  
 SHOW ME HEALTHY MISSOURIANS/SHOW ME HEALTHY WOMEN  
**PATIENT HISTORY**  
 (TO BE COMPLETED BY CLIENT AND REVIEWED ANNUALLY)

P. O. Box 570  
 Jefferson City, MO 65102-0570  
 (573) 522-2845

ENROLLMENT SITE/SATELLITE CLINIC (IF ANY)			DATE OF VISIT (MM/DD/YYYY)		
<b>A. PERSONAL HISTORY</b>					
NAME (LAST, FIRST, MIDDLE INITIAL)				MAIDEN NAME	
E-MAIL ADDRESS		HOME PHONE NO. ( ) ( )	WORK PHONE NO. ( ) ( )	CELL PHONE NO. ( ) ( )	
STREET ADDRESS		CITY/STATE	ZIP CODE	COUNTY	
DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER (OPTIONAL)		WHAT IS THE PRIMARY LANGUAGE SPOKEN IN YOUR HOME? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____		
NUMBER OF HOUSEHOLD MEMBERS	INSURANCE COVERAGE <input type="checkbox"/> None <input type="checkbox"/> No HealthNet <input type="checkbox"/> Medicare <input type="checkbox"/> Private			MEDICAID DCN/MEDICARE NUMBER	
Race: (must be answered, choose all that apply) <input type="checkbox"/> (1) White <input type="checkbox"/> (2) Black or African American <input type="checkbox"/> (3) Asian <input type="checkbox"/> (4) Native Hawaiian or Other Pacific Islander <input type="checkbox"/> (5) American Indian or Alaskan Native <input type="checkbox"/> (6) Other _____ <input type="checkbox"/> (7) Unknown (please avoid using)			Ethnicity: (must be answered.) Are you of Hispanic origin? <input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> Highest grade of school completed (circle one) (U. S. equivalent if educated in another nation) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16		
How did you hear about the Show Me Healthy Women program? (please choose only one) <input type="checkbox"/> (1) Physician <input type="checkbox"/> (8) Health Care Provider <input type="checkbox"/> (2) Clinic <input type="checkbox"/> (9) Health Fair <input type="checkbox"/> (3) Television <input type="checkbox"/> (10) Health Coalition <input type="checkbox"/> (4) Radio <input type="checkbox"/> (11) Outreach Worker <input type="checkbox"/> (5) Printed Ad <input type="checkbox"/> (12) Relative/Friend <input type="checkbox"/> (6) Billboard <input type="checkbox"/> (13) Other Location (specify) _____ <input type="checkbox"/> (7) Bus Sign			What type of transportation did you use to get to your clinic appointment? (please choose only one) <input type="checkbox"/> (1) Bus <input type="checkbox"/> (2) ACT Van <input type="checkbox"/> (3) OATS Bus <input type="checkbox"/> (4) Taxi <input type="checkbox"/> (5) Personal Vehicle <input type="checkbox"/> (6) Relative/Friend <input type="checkbox"/> (7) SMTS <input type="checkbox"/> (8) Other _____		
Date of last Pap Test    ____/____/____ <small>MM    DD    YYYY</small>			Date of Last mammogram    ____/____/____ <small>MM    DD    YYYY</small>		
Do you now smoke cigarettes? <input type="checkbox"/> Everyday <input type="checkbox"/> Some days <input type="checkbox"/> Not at all <input type="checkbox"/> Don't know					
Name and telephone numbers of two people who can always reach you:					
NAME		HOME PHONE WITH AREA CODE		WORK PHONE	
		( ) _____		( ) _____	
NAME		HOME PHONE WITH AREA CODE		WORK PHONE	
		( ) _____		( ) _____	

# 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.

 MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES BUREAU OF CANCER AND CHRONIC DISEASE CONTROL SHOW ME HEALTHY WOMEN (SMHW) <b>SCREENING REPORT</b>		P. O. Box 570 Jefferson City, MO 65102-0570 (573) 622-2845	
ENROLLMENT SITE/SATELLITE SITE (NAME AND ADDRESS)		REFERRING PROVIDER (FOR DIRECT BILLING)	
<b>A. PERSONAL DATA</b>			
NAME (LAST, FIRST, MIDDLE INITIAL)		SOCIAL SECURITY NUMBER	
DATE OF BIRTH MM / DD / YYYY	CLIENT ELIGIBILITY VERIFIED <input type="checkbox"/> Yes <input type="checkbox"/> No	INSURANCE COVERAGE <input type="checkbox"/> Yes <input type="checkbox"/> No	DEDUCTIBLE MET <input type="checkbox"/> Yes <input type="checkbox"/> No
VISIT TYPE <input type="checkbox"/> Initial <input type="checkbox"/> Annual <input type="checkbox"/> Initial CBE only <input type="checkbox"/> Annual CBE only	<input type="checkbox"/> Rescreen <input type="checkbox"/> Mammogram only	Height ft. in.	Weight lbs.
		BMI	Blood Pressure 1st Reading: / / 2nd Reading: / / Average: / /
		REFERRAL FEE <input type="checkbox"/>	
		MEDICARE <input type="checkbox"/> Part A <input type="checkbox"/> Part A and B	
<b>B. BREAST CANCER SCREENING</b> <span style="float: right;"><input type="checkbox"/> Reporting Only</span>			
B 1. Does client report any BSE symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No (If YES* complete B2.) Date of CBE: / / (MM/DD/YYYY)			
B 2. Symptoms Reported By Client (Check any that apply. If 1, 2, 3 or 4B is checked, may have two (2) diagnostics at clinician's discretion.)			
<input type="checkbox"/> (1) Lump		<input type="checkbox"/> (4A) Pain/Tenderness - 1st occurrence	
<input type="checkbox"/> (2) Nipple discharge		<input type="checkbox"/> (4B) Pain/Tenderness - 2nd occurrence	
<input type="checkbox"/> (3) Skin changes (dimpling, retraction, new nipple inversion, ulceration, Paget's disease)		<input type="checkbox"/> (5) Other (specify) _____	
B 3. CBE within normal limits and findings Present at CBE (check yes or no and one explanation)			
<input type="checkbox"/> Yes <input type="checkbox"/> Within normal limits			
<input type="checkbox"/> (1) Benign finding (fibrocystic changes, diffuse lumpiness, clearly defined thickening, tenderness or nodularity)			
<input type="checkbox"/> No - Suspicious for cancer (Any checked findings requires completion of two (2) diagnostic procedures entered on purple breast form.)			
<input type="checkbox"/> (2) Discrete palpable mass (Includes masses that may be diffuse, poorly defined thickening, cystic or solid)		<input type="checkbox"/> (5) Skin dimpling/retraction; new nipple inversion; peau d'orange; ulceration; one breast lower than usual; prominent veins, unilateral; unusual increase in size, unilateral	
<input type="checkbox"/> (3) Nipple discharge		<input type="checkbox"/> (6) Enlarged, tender, fixed or hard palpable supraclavicular, infraclavicular or axillary lymph nodes; also swelling of upper arm	
<input type="checkbox"/> (4) Nipple or areolar scalliness or erythema			
B 4. Risk for Breast Cancer <input type="checkbox"/> (1) Average <input type="checkbox"/> (3) Not assessed			
<input type="checkbox"/> (2) High/increased		<input type="checkbox"/> (9) Unknown	
Rescreen CBE Planned <input type="checkbox"/> Yes <input type="checkbox"/> No / / (MM / YYYY) <small>(must be less than 10 months)</small>		Diagnostic Work-up Planned <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(must be less than 60 days)</small> / / (MM / DD / YYYY)	
<b>B 5. Mammogram Results</b> <span style="float: right;"><input type="checkbox"/> Reporting Only</span>			
<input type="checkbox"/> (4) Mammogram not done or CBE done and diagnostic workup planned		<input type="checkbox"/> (5) Cervical record only, no breast service provided	
<input type="checkbox"/> (1) Routine screening mammogram		<input type="checkbox"/> (6) Referred to direct biller	
<input type="checkbox"/> (2) Mammogram performed to evaluate symptoms: <input type="checkbox"/> Positive BSE <input type="checkbox"/> Positive CBE <input type="checkbox"/> Personal history of breast cancer <input type="checkbox"/> Previous abnormal mammogram results (rescreen)		<input type="checkbox"/> (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: / / (MM / DD / YYYY)	
Mammography provider facility (facility name/city)		<input type="checkbox"/> Mammogram Van	
Previous mammogram <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date of last mammogram: / / (MM / YYYY)	
		Date of this mammogram: / / (MM / DD / YYYY)	
Type of mammogram <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic		Method used for mammogram <input type="checkbox"/> Digital <input type="checkbox"/> Conventional	
SMHW mammogram result (check one) (results with * require additional follow-up)			
Left: Right: (Indicate why only one breast had mammogram in COMMENTS)		Left: Right:	
Normal <input type="checkbox"/> (1) Negative (Category 1)		Abnormal <input type="checkbox"/> (3) Probably Benign (Category 3)	
<input type="checkbox"/> (2) Benign Finding (Category 2)		<input type="checkbox"/> (4) Suspicious Abnormality (Category 4)*	
Further diagnostic planned for: (3) Probably Benign: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> (5) Highly Suggestive of Malignancy (Category 5)*	
		<input type="checkbox"/> (14) Need evaluation or film comparison (Category 0)	
Rescreen mammogram planned <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(must be less than 10 months)</small> / / (MM / YYYY)		Diagnostic work-up planned <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(must be less than 60 days)</small> / / (MM / DD / YYYY)	
Referred for diagnostic testing/direct bill (physician/facility name)			
<b>(Cervical Cancer Screening Report on back of this form.)</b>			
MO 580-1799 (8-16)		Ch. D-1	

### C. CERVICAL CANCER SCREENING

- (5) Breast and Pelvic exam only  (1) Routine Pap test  
 (2) Patient under surveillance for previous abnormal (rescreen)  
 (4) Pap test not done. Patient proceeded directly for diagnostic work-up or HPV testing  
 (6) Referred to direct biller for Pap and Pelvic  
 (3) Abnormal Pap test done by non-program provider - reporting only/referral date      /      /       
MM DD YYYY

#### Risk for Cervical Cancer

- (1) Average  
 (2) High/Increased  
 (4) Not assessed  
 (5) Unknown

#### C 1. Pelvic Exam Results

Pelvic Exam WNL?  Yes  No  
(Additional information required in "No" selected, See C 2.)

Hysterectomy?  Yes  No

- Cervix absent  
 Cervix absent due to cervical cancer  
(needs annual Pap test)  
 Cervix present  
 Reason for hysterectomy unknown

Date of Pelvic Exam      /      /       
MM DD YYYY

Reproductive Status (check one)

- a) Premenopausal  
 b) Postmenopausal

#### C 2. Pelvic Exam Findings

Reporting Only

Findings Present at Pelvic Exam (check only one)

##### 1) Cervix

- a) Polyp  f) Ectropion  
 b) Leukoplakia (white lesions)  g) Stenotic CG  
 c) Friable  h) Cervical mass  
 d) Ulceration  i) Other:                       
 e) Exophytic growth

##### 2) Exam Complicated by Obesity

Rescreen planned  Yes  No      /       
MM YYYY

Diagnostic planned  Yes  No      /      /       
MM DD YYYY  
(must be less than 90 days)

#### C 3. Pap Test Results

Reporting Only

Previous Pap test  Yes  No  Unknown

Date of last Pap test      /       
MM YYYY

Date of this Pap test      /      /       
MM DD YYYY

Specimen adequacy  Satisfactory  
 Unsatisfactory due to                                       
 Unknown

Specimen type  Conventional Smear  
 Liquid Based  
 Annual Pap due to previous treatment for cervical cancer

Pap test result (check one) (Results with (\*) require additional follow-up)

- Normal  (1) Negative for Intraepithelial lesion or malignancy  
 (2) Infection/Inflammation/Reactive Change
- Abnormal  (3) Atypical Squamous Cells of Undetermined Significance  
(ASC-US)(May have HPV test)  
 (4) Lowgrade SIL (HPV/Mild Dysplasia/CIN I)\*  
 (5) Atypical Squamous Cells, cannot exclude HSIL (ASC-H)\*  
 (6) Highgrade SIL (with features suspicious for invasion/CIN II-III/CIS)\*
- (7) Squamous Cell Cancer\*  
 (8) Atypical Glandular Cells\* (including atypical/endocervical adenocarcinoma in situ and adenocarcinoma)  
 (9) Adenocarcinoma in situ  
 (10) Adenocarcinoma  
 (11) Other:

Endocervical Cells  Yes  No

C 4. HPV Test Date      /      /      MMDDYYYY

Reporting Only

Indication for HPV Test  (1) Cotesting/Screening  
 (2) Triage (Reflex)  
 (3) Not Done  
 (9) Unknown

HPV Test Result  (1) Positive (High Risk)  
 (2) Negative

HPV DNA Genotype 16 or 18 Positive (Only report if PAP negative and HPV High Risk Group Positive)  
 Yes  
 No  
 No Test Performed

Rescreen Pap planned  Yes  No      /       
(less than 10 months) MM YYYY

Diagnostic work-up planned  Yes  No      /      /       
(must be less than 90 days) MM DD YYYY


Referred for diagnostic work-up/direct biller  
(physician/facility name)

Date of next routine Pap screening      /       
MM YYYY

#### D. COMMENTS

## 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.

 MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES BUREAU OF CANCER AND CHRONIC DISEASE CONTROL SHOW ME HEALTHY MISSOURIANS/SMHW <b>BREAST DIAGNOSIS AND TREATMENT</b>		P. O. Box 570 Jefferson City, MO 65102-0570 (573) 522-2845																													
ENROLLMENT SITE/SATELLITE (NAME AND ADDRESS)		REFERRING PROVIDER (FOR DIRECT BILLING)																													
<b>A. PERSONAL DATA</b>																															
NAME (LAST, FIRST, MIDDLE INITIAL)																															
DATE OF BIRTH MM / DD / YYYY	SOCIAL SECURITY NUMBER - - - - -		CLIENT ELIGIBILITY VERIFIED <input type="checkbox"/> Yes <input type="checkbox"/> No																												
INSURANCE COVERAGE <input type="checkbox"/> Yes <input type="checkbox"/> No	DEDUCTIBLE MET <input type="checkbox"/> Yes <input type="checkbox"/> No	REFERRAL FEE <input type="checkbox"/>	TYPE OF MEDICARE <input type="checkbox"/> Part A <input type="checkbox"/> Part A and B																												
			BCCT <input type="checkbox"/> Yes <input type="checkbox"/> No																												
<b>B. BREAST DIAGNOSTIC PROCEDURES</b> <span style="float: right;"><input type="checkbox"/> Reporting only</span>																															
Diagnostic Mammogram <input type="checkbox"/> Conventional <input type="checkbox"/> Digital <span style="float: right;">MM / DD / YYYY</span>																															
Additional Mammographic view(s)																															
<table border="0"> <tr> <td></td> <td>L</td> <td>R</td> <td></td> </tr> <tr> <td>Normal</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>(1) Negative (Category 1)</td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>(2) Benign Finding (Category 2)</td> </tr> <tr> <td>Abnormal</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>(3) Probably Benign (Category 3)</td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>(4) Suspicious Abnormality (Category 4)</td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>(5) Highly Suggestive of Malignancy (Category 5)</td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>(14) Additional Imaging Pending (Category 0)</td> </tr> </table>					L	R		Normal	<input type="checkbox"/>	<input type="checkbox"/>	(1) Negative (Category 1)		<input type="checkbox"/>	<input type="checkbox"/>	(2) Benign Finding (Category 2)	Abnormal	<input type="checkbox"/>	<input type="checkbox"/>	(3) Probably Benign (Category 3)		<input type="checkbox"/>	<input type="checkbox"/>	(4) Suspicious Abnormality (Category 4)		<input type="checkbox"/>	<input type="checkbox"/>	(5) Highly Suggestive of Malignancy (Category 5)		<input type="checkbox"/>	<input type="checkbox"/>	(14) Additional Imaging Pending (Category 0)
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	<input type="checkbox"/>	<input type="checkbox"/>	(14) Additional Imaging Pending (Category 0)																												
Ultrasound <span style="float: right;"><input type="checkbox"/> Rescreen <input type="checkbox"/> Reporting only</span>																															
MM / DD / YYYY																															
Left: <input type="checkbox"/> Complete <input type="checkbox"/> Limited Right: <input type="checkbox"/> Complete <input type="checkbox"/> Limited		<table border="0"> <tr> <td></td> <td>L</td> <td>R</td> <td></td> </tr> <tr> <td>Normal</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>(1) Negative (Category 1)</td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>(2) Benign Finding (Category 2)</td> </tr> <tr> <td>Abnormal</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>(3) Probably Benign (Category 3)</td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>(4) Suspicious Abnormality (Category 4) - Refer to BCCT</td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>(5) Highly Suggestive of Malignancy (Category 5) - Refer to BCCT</td> </tr> <tr> <td>Other</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>(7) Unsatisfactory - not interpreted - repeat (not paid)</td> </tr> </table>			L	R		Normal	<input type="checkbox"/>	<input type="checkbox"/>	(1) Negative (Category 1)		<input type="checkbox"/>	<input type="checkbox"/>	(2) Benign Finding (Category 2)	Abnormal	<input type="checkbox"/>	<input type="checkbox"/>	(3) Probably Benign (Category 3)		<input type="checkbox"/>	<input type="checkbox"/>	(4) Suspicious Abnormality (Category 4) - Refer to BCCT		<input type="checkbox"/>	<input type="checkbox"/>	(5) Highly Suggestive of Malignancy (Category 5) - Refer to BCCT	Other	<input type="checkbox"/>	<input type="checkbox"/>	(7) Unsatisfactory - not interpreted - repeat (not paid)
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Other	<input type="checkbox"/>	<input type="checkbox"/>	(7) Unsatisfactory - not interpreted - repeat (not paid)																												
Specialist Consultation Date <span style="float: right;">MM / DD / YYYY</span>		Diagnostic Work-up Planned <input type="checkbox"/> None <input type="checkbox"/> 0-30 days <input type="checkbox"/> 61-90 days <span style="float: right;"><input type="checkbox"/> Reporting only</span>																													
CBE WNL <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No" indicate finding below)																															
Benign finding <input type="checkbox"/> (1) Fibrocystic changes, diffuse lumpiness, clearly defined thickening, or nodularity Suspicious for cancer <input type="checkbox"/> (2) Discrete palpable mass <input type="checkbox"/> (3) Nipple discharge <input type="checkbox"/> (4) Nipple or areolar scaliness or erythema <input type="checkbox"/> (5) Skin dimpling, retraction, new nipple inversion, peau d'orange, ulceration; also one breast lower than usual; or unilateral prominent veins, or unilateral increase in size <input type="checkbox"/> (6) Enlarged, tender, fixed, or hard palpable supraclavicular, infraclavicular, or axillary lymph nodes; also swelling of upper arm																															
Fine Needle/Cyst Aspiration <span style="float: right;">MM / DD / YYYY</span>		Cytopathology Performed <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="float: right;"><input type="checkbox"/> Reporting only</span>																													
<b>Left Breast</b> Type <input type="checkbox"/> Superficial <input type="checkbox"/> Deep tissue under guidance Result <input type="checkbox"/> (1) Negative <input type="checkbox"/> (2) Indeterminate <input type="checkbox"/> (3) Suspicious for Malignancy - Refer to BCCT <input type="checkbox"/> (4) Malignancy - Refer to BCCT		<b>Right Breast</b> Type <input type="checkbox"/> Superficial <input type="checkbox"/> Deep tissue under guidance Result <input type="checkbox"/> (1) Negative <input type="checkbox"/> (2) Indeterminate <input type="checkbox"/> (3) Suspicious for Malignancy - Refer to BCCT <input type="checkbox"/> (4) Malignancy - Refer to BCCT																													
MO 580-1798 (7-18)		Ch. D-2																													



**Biopsy** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Reporting only

**Location**  Physician Office  Hospital outpatient  Facility Fee  Yes  No  Anesthesia

**Primary Biopsy Type: Clear**

**Breast**  
 Left  Right  Stereotactic Guided (19081)  Add Lesion  Additional Primary Pathology:  
 U.S. Guided (19083)  No additional pathology  
 Needle Core, No Guidance (19100)  1 additional pathology  
 Incisional, No Guidance (19101)  Mammogram Guided (19281)  Stereotactic Guided (19283)  US Guided (19285)  2 additional pathology  
 Excisional (19120 or 19125)  Preoperative placement of clip?  Yes  No  3 additional pathology  
 Radiological exam?  Yes  No

**Additional Lesion: Clear**  
 Incisional, No Guidance (19101)  Mammogram Guided  Stereotactic Guided  US Guided  Additional Primary Pathology:  
 Excisional (19120)  Preoperative placement of clip?  Yes  No  No additional pathology  
 Radiological exam?  Yes  No  1 additional pathology  
 2 additional pathology  
 3 additional pathology

**Additional Facility Fee**  Yes  No

**Biopsy Result** (Report only most severe result)  
 (1) Benign  
 (2) Benign/Atypical  
 (3) Indeterminate  
 (4) Malignancy

**Status of Final Diagnosis**  
 (1) Work-up Complete (Complete Section C)  
 (2) Work-up Pending  
 (3) Lost to Follow-up (Enter Lost to Follow-up Date in Final Diagnosis Date)  
 (4) Work-up Refused (Describe in comment section/Must have signed waiver)  
 (9) Irreconcilable (Does not follow typical protocol - Describe)

**Next Breast Cancer Screening Date** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ MM/YY

**Other Procedure (specify):** \_\_\_\_\_ **Other Procedure Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ MM/YY

**C. BREAST DIAGNOSIS**

**Final Diagnosis**  
 (3) Breast Cancer not diagnosed  
 (4) Lobular Carcinoma In Situ (LCIS) (Stage 0)\*  
 (5) Ductal Carcinoma In Situ (DCIS) (Stage 0)\*  
 (2) Invasive Breast Cancer\*

**Final Diagnosis/Imaging Date** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ MM/YY

**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/Must have signed waiver)  
 (5) Not Needed

**Type**  
 (1) Surgery  
 (2) Radiation  
 (3) Chemotherapy  
 (4) Hormone  
 (5) Immunotherapy  
 (6) Other Cancer Therapy  
Specify \_\_\_\_\_


**Treatment Facility**  
(Facility Name/City)

**Date Treatment Started** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ MM/YY

**COMMENTS**

## 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.

 MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES BUREAU OF CANCER AND CHRONIC DISEASE CONTROL SHOW ME HEALTHY MISSOURIANS/SMHW <b>CERVICAL DIAGNOSIS AND TREATMENT</b>		P. O. Box 570 Jefferson City, MO 65102-0570 (573) 522-2845	
ENROLLMENT SITE/SATELLITE (NAME AND ADDRESS)		REFERRING PROVIDER (FOR DIRECT BILLING)	
<b>A. PERSONAL DATA</b>			
NAME (LAST, FIRST, MIDDLE INITIAL)			
DATE OF BIRTH MM / DD / YYYY	SOCIAL SECURITY NUMBER		CLIENT ELIGIBILITY VERIFIED <input type="checkbox"/> Yes <input type="checkbox"/> No
INSURANCE COVERAGE <input type="checkbox"/> Yes <input type="checkbox"/> No	DEDUCTIBLE MET <input type="checkbox"/> Yes <input type="checkbox"/> No	REFERRAL FEE <input type="checkbox"/>	TYPE OF MEDICARE <input type="checkbox"/> Part A <input type="checkbox"/> Part A and B
<b>B. CERVICAL DIAGNOSTIC PROCEDURES</b>			
Specialist Consultation		MM / DD / YYYY	<input type="checkbox"/> Reporting Only
Diagnostic Work-up Planned <input type="checkbox"/> None <input type="checkbox"/> 0-80 Days <input type="checkbox"/> 81-90 days			
<input type="checkbox"/> Colposcopy without Biopsy		MM / DD / YYYY	<input type="checkbox"/> Reporting Only
<input type="checkbox"/> Colposcopy		MM / DD / YYYY	<input type="checkbox"/> Reporting Only
<input type="checkbox"/> Polypectomy		MM / DD / YYYY	<input type="checkbox"/> Reporting Only
<input type="checkbox"/> Cervical Biopsy <input type="checkbox"/> Endocervical Biopsy/ECC Biopsy <input type="checkbox"/> Endometrial Biopsy (Can only be reimbursed with cervical biopsy)			
<input type="checkbox"/> 1 Additional Cervical Biopsy <input type="checkbox"/> 2 Additional Cervical Biopsies <input type="checkbox"/> 3 Additional Cervical Biopsies			
<input type="checkbox"/> Colposcopy inadequate, need further diagnostic			
Diagnostic procedures, choose ONLY one		MM / DD / YYYY	<input type="checkbox"/> Reporting Only
<input type="checkbox"/> LEEP ← OR → <input type="checkbox"/> Cold Knife ← OR → <input type="checkbox"/> Endocervical Curettage (alone)			
<input type="checkbox"/> (1) Biopsy <input type="checkbox"/> (2) 1 Additional Biopsy <input type="checkbox"/> (3) 2 Additional Biopsies <input type="checkbox"/> (4) 3 Additional Biopsies			
Other Cervical Procedure (specify)		MM / DD / YYYY	
Next Cervical Cancer Screening Date		MM / YYYY	
<b>Status of Final Diagnosis</b>			
<input type="checkbox"/> (1) Work-up Complete (Complete Section C) <input type="checkbox"/> (2) Work-up Pending <input type="checkbox"/> (3) Lost to F/U (Describe in comment section) <input type="checkbox"/> (4) Work-up Refused (Describe in comment section/Must have signed waiver) <input type="checkbox"/> (5) Irreconcilable (Does not follow typical protocol - Describe)			

**C. CERVICAL DIAGNOSIS**

Final Diagnosis (RECORD MOST SEVERE RESULT) *(Diagnostic results with (\*) require treatment)*

- (1) Normal/Benign Reactive/Inflammation
- (2) HPV/Condylomata/Atypia
- (3) CIN I/Mild Dysplasia/Low grade SIL (Biopsy Diagnosed)\*
- (4) CIN II/Moderate Dysplasia (Biopsy Diagnosed)\* (Refer to BCCT)
- (5) CIN III/Severe Dysplasia/High Grade SIL/Carcinoma In Situ (CIS), Stage 0 (Biopsy Diagnosed)\* (Refer to BCCT)
- (6) Invasive (Biopsy Diagnosed)\* (Refer to BCCT)
- (7) Other \_\_\_\_\_

Final Diagnosis Date \_\_\_\_\_  
MM / DD / YYYY

**D. CERVICAL TREATMENT**

**Status of Treatment**

- Started
- Pending
- Lost to F/U (Describe in comment section)
- Work up refused (Describe in comment section/Must have signed waiver)
- Not Needed

**Type**

- Cryotherapy
- Conization (LEEP, Cold Knife)
- Radiation Therapy
- Chemotherapy
- Surgery
- Immunotherapy
- Other Cancer Therapy - Specify \_\_\_\_\_

Treatment Facility  
Facility Name/City

Date Treatment Started \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM / DD / YYYY

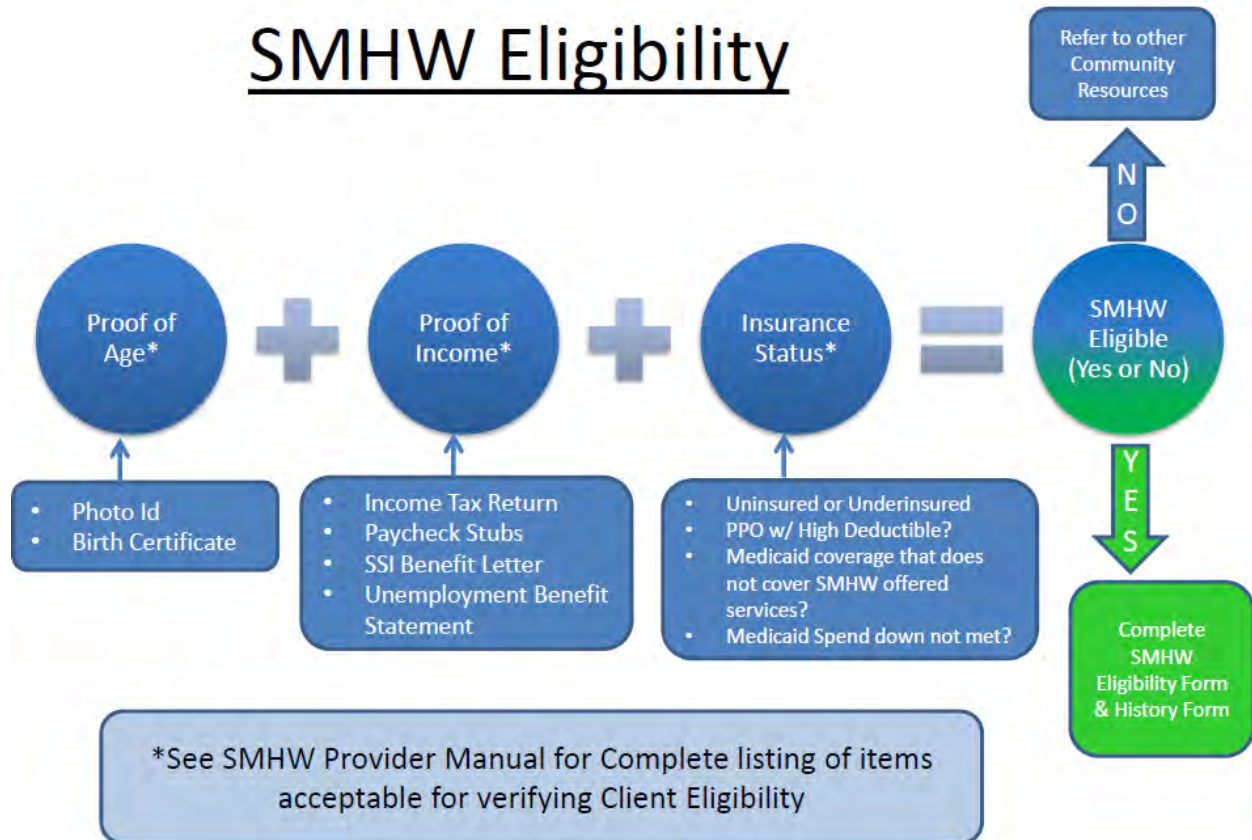
**Comments**

## 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

# SMHW Eligibility

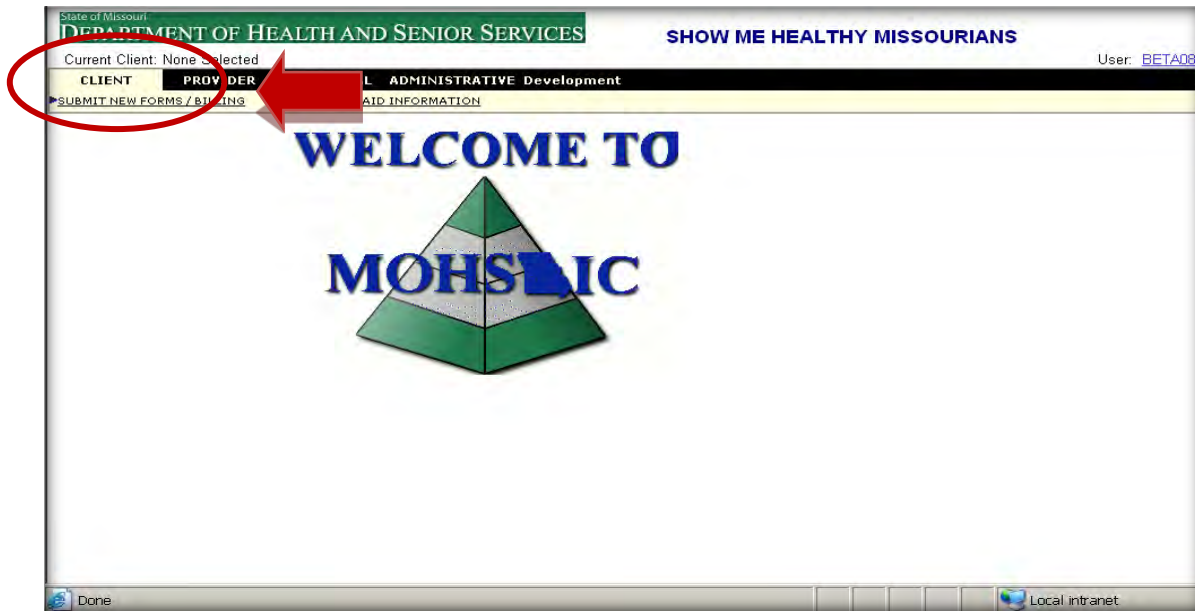


## CLAIM SUBMISSION

### *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'



## 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  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** **SHOW ME HEALTHY MISSOURIANS**

Current Client: None Selected

**CLIENT** PROVIDER FINANCIAL ADMINISTRATIVE Development

▼SUBMIT NEW FORMS / BILLING ►VIEW INFORMATION

Show Instructions

### Submit Form

#### Client Information

Client Name: [Dropdown] ? [Update Client Information](#)

Address: [Text Box]

SSN: [Text Box] Sex: [Text Box]  
DOB: [Text Box] Race: [Text Box]  
DCN: [Text Box] Ethnicity: [Text Box]

City, State Zip: [Text Box], MO [Text Box] Phone: [Text Box] - [Text Box] - [Text Box]  No Phone

#### Provider Information

Regular Billing  Direct Billing

Provider: [Dropdown] Referring Provider: [Dropdown]

Service Name/Address: [Text Box]

#### Form Type/Version

Type: [Dropdown]  
Version: [Dropdown]

Done Loca

### 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  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** **SHOW ME HEALTHY MISSOURIANS**

Current Client: None Selected

**CLIENT** PROVIDER FINANCIAL ADMINISTRATIVE Development

▼SUBMIT NEW FORMS / BILLING ►VIEW MEDICAID INFORMATION

Show Instructions

Submit Form

**Client Information**

Client Name: jane, doe ? Update Client Information

Address: 2 of 2 retrieved. Make a selection, Refine Search or Press tab key to continue.

Name	DOB	DCN	Address	PartyID
JANET, DOE M		12345678		378223108
JANET, DOE M		12345678		378223116

City, State Zip

**Provider Inform**

Provider

Service Name/Address

**Form Type/Version**

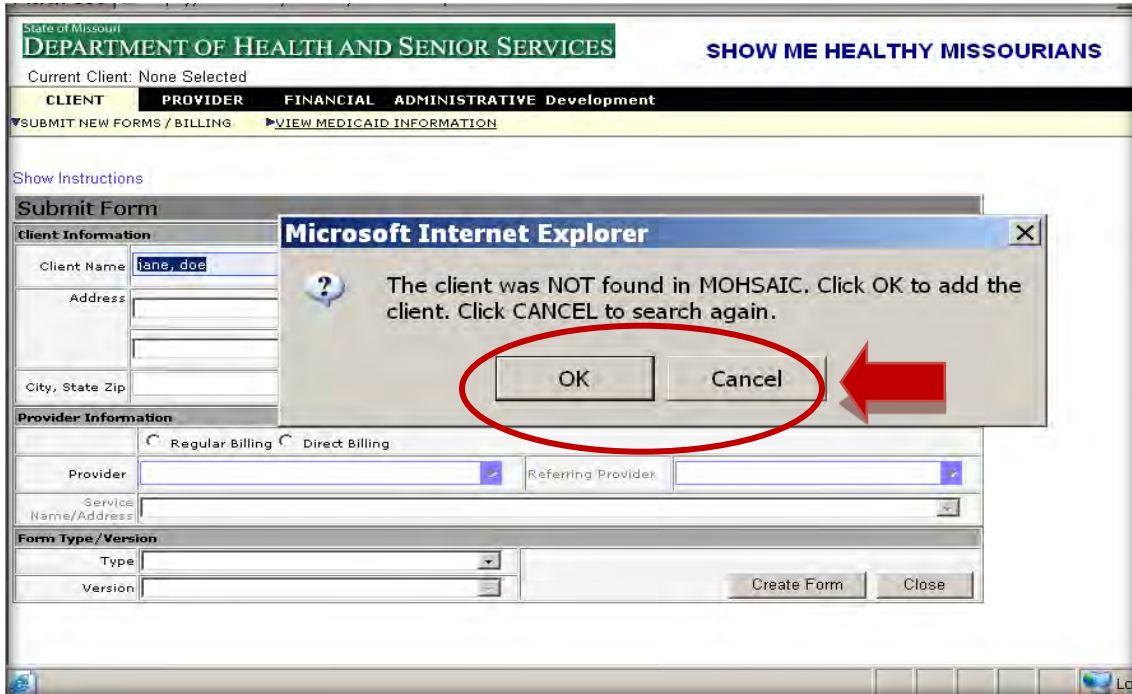
Type

Version

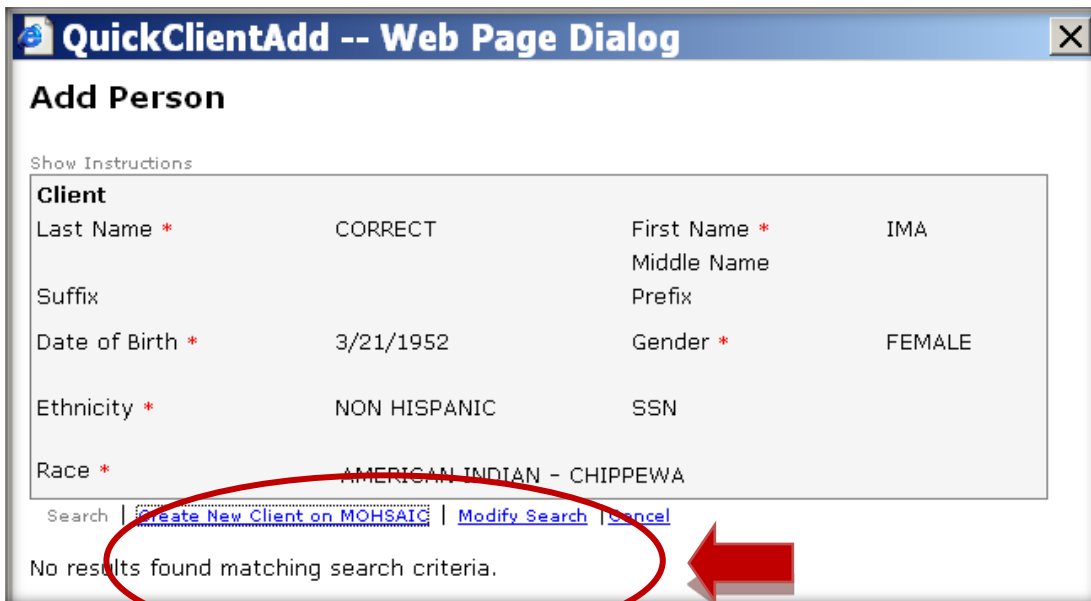
Create Form Close

### 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.



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.





## 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  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** **SHOW ME HEALTHY MISSOURI**

Current Client: REAL, GET No Address Found No Phone Information Found User: [ ]

**CLIENT** **FINANCIAL**

▼SUBMIT NEW FORMS / BILLING ▶VIEW MEDICAID INFORMATION

[Show Instructions](#)

### Submit Form

#### Client Information

Client Name	REAL, GET	Update Client Information				
Address		SSN	555-66-5551	Sex	FEMALE	
		DOB	12/12/1951	Race	WHITE	
		DCN	63045647	Ethnicity	NON HISPANIC	
City, State Zip		MO		Phone	- - -	<input type="checkbox"/> No Phone

#### Provider Information

Regular Billing  Direct Billing

Provider: SHANNON COUNTY HEALTH DEPARTMENT Referring Provider: [ ]

Service Name/Address: OREGON COUNTY HEALTH DEPARTMENT - 119 GREY JONES STREET, EMINENCE, MO 65466

#### Form Type/Version

Type: [ ]

Version: [ ]

Done Local intranet

### 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.

**Address Verification**

- The address entered could not be completely verified.
- Either the address could not be validated or multiple addresses were found that could possibly be the address being entered.
- Select one of the possible addresses or accept the address as entered.

Show Instruction

**Address Verification**

Invalid Address	<b>NOTE: This address will be marked as OVERRIDE.</b> 164 SYCAMORE LN JEFFERSON CITY, MO 65109 County <input type="text"/>
Valid Addresses	The lower score number indicates a closer address match. No valid addresses were found.

[Save](#) | [Cancel](#)

### 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 AND SENIOR SERVICES** **SHOW ME HEALTHY MISSOURIA**  
User: BETA

**CLIENT** **FINANCIAL**  
▶ [SUBMIT NEW FORMS / BILLING](#) ▼ [VIEW MEDICAID INFORMATION](#)

Client - ROSES, MERRY [Change Client](#)

Client's Medicaid Status	
Status	Status Date

Parent/Guardian Medicaid Case Information			
DCN		Status	
Telephone			
Address 1			
Address 2			
City		State	Zip

Client's Medicaid Dates				
Begin Date	End Date	Program	Level Of Care	ME Code
1				

Client's Managed Care(Medicaid Only)			
Plan	Begin Date	End Date	Plan Number
1			

[Close](#)

Done Local 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.

The screenshot displays the Missouri Department of Health and Senior Services web application. The header includes the state logo and the text "SHOW ME HEALTHY MISSOURIA". The user is identified as "User: BETA". The main navigation bar contains tabs for "CLIENT", "PROVIDER", "FINANCIAL", and "ADMINISTRATIVE Development". Below this, there are links for "SUBMIT NEW FORMS / BILLING" and "VIEW MEDICAID INFORMATION".

The "Client's Medicaid Status" section shows a status of 0 and a status date. The "Parent/Guardian Medicaid Case Information" section includes fields for DCN (18053885), Status (5), Telephone, Address 1 (1007 INTL AVE BOX 605), Address 2, City (JOPLIN), State (MO), and Zip (64801).

The "Client's Medicaid Dates" section is a table with columns for Begin Date, End Date, Program, Level Of Care, and ME Code. It contains three rows of data, all with a Program of "AC" and Level Of Care of "AC". The first row has a Begin Date of 9/1/2002 and an End Date of 5/28/2006. The second and third rows also have a Begin Date of 9/1/2002 and an End Date of 5/28/2006. A red circle highlights the first two rows, and a red arrow points from the circle to the "Client's Managed Care(Medicaid Only)" section below.

The "Client's Managed Care(Medicaid Only)" section is a table with columns for Plan, Begin Date, End Date, and Plan Number. It contains one row with a Plan of 1.

At the bottom of the page, there is a "Close" link and a "Local intranet" icon.

Please remember when pulling up or entering another client under client demographics, **verify** 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  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** **SHOW ME HEALTHY MISSOURI**

Current Client: DOE, JANE A 1415 S EVANSTON, JEFFERSON CITY, MO 64108 No Phone Information Found

**CLIENT** PROVIDER FINANCIAL STRATEGIC Development

▶ SUBMIT NEW FORMS / BILLING ▶ VIEW MEDICAID INFORMATION

Show Instructions

### Submit Form

**Client Information** – Please verify address and demographics below and update as needed.

Client Name	DOE, JANE A	Update Client Information			
Address	1234 PINEAPPLE LN	SSN	123-45-6789	Sex	FEMALE
		DOB	4/24/1949	Race	WHITE
		DCN	63045628	Ethnicity	NON HISPANIC
City, State Zip	JEFFERSON CITY, MO 65102	Phone	<input type="checkbox"/> No Phone		

**Provider Information**

Regular Billing  Direct Billing

Provider: OREGON COUNTY HEALTH DEPARTMENT Referring Provider:

Service Name/Address: JONES, INDIANA K - 416 MARKET STREET, ALTON, MO 65606

**Form Type/Version**

Type: Patient History (Green)

Version: Forms for Services Provided On or After June 30, 2007

Create Form Close

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 Missouri  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** SHOW ME HEALTHY MISSOURI

Current Client: PERSON, NOTA 88888888 RANDOM STREET JACKSON, KS 65109 County: ADAIR (458) 869-5236

**CLIENT** PROVIDER FINANCIAL ADMINISTRATIVE

▼SUBMIT NEW FORMS / BILLING ▶VIEW MEDICAID INFORMATION

### Submit Form

**Client Information** -- Please verify address and demographics below and update as needed.

Client Name: PERSON, NOTA ? Update Client Information

Address: 88888888 RANDOM STREET

SSN: [ ] - [ ] - [ ]  SSN Not Available

DOB: 1/1/1901 Sex: FEMALE  
DCN: 62217117 Race: PACIFIC ISLANDER -  
Ethnicity: HISPANIC

City, State, Zip: JACKSON, KS 65109 Phone: 458 - 869 - 5236  No Phone

**Provider Information**

Regular Billing  Direct Billing

Provider: [ ] Referring Provider: [ ]

Service Name/Address: [ ]

**Form Type/Version**

Type: Patient History (Green) Create Form Close

Version:

- Breast Diagnosis and Treatment (Purple)
- Cervical Diagnosis and Treatment (Yellow)
- Patient History (Green)**
- Screening Reporting Form (Blue)
- WISEWOMAN Form
- Colorectal History Form
- Colorectal Screening Form

Page: 2 of 4 Words: 29

## 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 June 30, 2018

State of Missouri  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** SHOW ME HEALTHY MISSOURI

Current Client: PERSON, NOTA 88888888 RANDOM STREET JACKSON, KS 65109 County: ADAIR (458) 869-5236

**CLIENT PROVIDER FINANCIAL ADMINISTRATIVE**

[SUBMIT NEW FORMS / BILLING](#) [VIEW MEDICAID INFORMATION](#)

### Submit Form

**Client Information** -- Please verify address and demographics below and update as needed.

Client Name	PERSON, NOTA	<a href="#">Update Client Information</a>	
Address	88888888 RANDOM STREET	SSN	<input type="text"/> - <input type="text"/> - <input type="text"/> <input type="checkbox"/> SSN Not Available
City, State, Zip	JACKSON, KS 65109	DOB	1/1/1901
Phone	458 - 869 - 5236	Sex	FEMALE
		Race	PACIFIC ISLANDER -
		Ethnicity	HISPANIC

**Provider Information**

Regular Billing  Direct Billing

Provider:  Referring Provider:

Service Name/Address:

**Form Type/Version**

Type:  Patient History (Green)

Version:  Forms for Services Provided On or After June 30, 2009

- 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, 2007
- 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

Local Intra

### 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** **SHOW ME HEALTH**

Current Client: BROWN, MARY 2322 W WASHINGTON UNIONVILLE, MO 90210 No Phone Information Found

**CLIENT PROVIDER FINANCIAL ADMINISTRATIVE Development**

▼SUBMIT NEW FORMS / BILLING ▶VIEW MEDICAID INFORMATION

Show Instructions

**Patient History** Ver. - 64

Provider SAMH Number - Service Address 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 015-65-5524

Medicaid DCN / Medicare Number 01565524

Ethnicity: NON HISPANIC

Race: . BLACK

Marital Status:

Date Form Received: MM/DD/YYYY

Date of Visit: MM/DD/YYYY

Number of Household Members Household Income (Monthly)

How did you hear about SMHW?

(1) Physician  (9) Health Fair

(2) Clinic  (10) Health Coalition

(3) Television  (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  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** SHOW ME HI

Current Client: ROSES, MERRY 164 SYCAMORE LN JEFFERSON CITY, MO 65109 (555) 222-4444 User: BETA

**CLIENT** FINANCIAL

▼SUBMIT NEW FORMS / BILLING ▶VIEW MEDICAID INFORMATION

Provider (16) Other Location

**B. CLINICAL BREAST EXAM RESULTS**  Reporting Only

Does client report any breast symptoms?  No Additional Information Required if "YES" Selected

CBE WNL  No Additional Information Required if "NO" Selected

**BENIGN FINDING:** Findings Present at CBE (check only one)

*SUSPICIOUS FOR CANCER (requires additional follow-up)*

1) Benign finding (fibrosystic changes, diffuse lumpiness, clearly defined thickening, tenderness or nodularity)

2) Discrete palpable mass (includes masses that may be diffuse, poorly defined thickening, cystic or solid)

3) Bloody or serous nipple discharge

4) Nipple or areola scaliness or erythema

5) Skin dimpling, retraction, new nipple inversion, peau d'orange, ulceration; also one breast lower than usual; prominent veins, unilateral; unusual increase in size, unilateral

6) Enlarged, tender, fixed, or hard palpable supraclavicular, infraclavicular, or axillary lymph nodes; also swelling of upper arm

Date of CBE 04/01/2008 MM/DD/YYYY

Rescreen Planned (less than 10 months)  No

Diagnostic Work-up Planned  Yes MM/YYYY

**C. MAMMOGRAM RESULTS**  Reporting Only

Mammogram Provider Facility Facility Name/City

Previous Mammograms

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.

State of Missouri  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** **SHOW ME H**

Current Client: ROSES, MERRY 164 SYCAMORE LN JEFFERSON CITY, MO 65109 (555) 222-4444 User: BET

**CLIENT** **FINANCIAL**

▼SUBMIT NEW FORMS / BILLING ▼VIEW MEDICAID INFORMATION

Show Instructions

### Screening Report

 Ver. - 64

Provider SAMH 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 63045683

Annual Visit Type

Referral Fee Client Eligibility Verified

No Insurance Coverage Deductible Met

Type of Medicare

How did you hear about SMHW?

(1) Physician  (9) Health Fair  
 (2) Clinic  (10) Health Coalition  
 (3) Television  (11) Outreach Worker  
 (4) Radio  (12) Relative/Friend  
 (5) Printed Art  (13) University Extension

Local intranet

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.

State of Missouri  
**DEPARTMENT OF HEALTH AND SENIOR SERVICES** **SHOW ME HEALTH**

Current Client: BROWN, MARY 2322 W WASHINGTON UNIONVILLE, MO 90210 No Phone Information Found

**CLIENT PROVIDER FINANCIAL ADMINISTRATIVE Development**

▼SUBMIT NEW FORMS / BILLING ▶VIEW MEDICAID INFORMATION

Have you had a hysterectomy?

If YES, what was the reason for having a hysterectomy?  
 Cervical Cancer/Dysplasia  Other   
 Benign Tumor  [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?

Any Errors Displayed Here Must Be Resolved to Submit

- Form Received Date 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

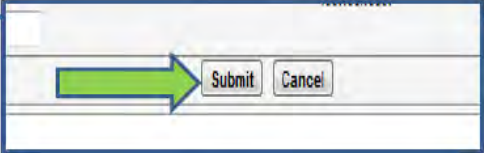
# SHOW ME HEALTHY WOMEN PATIENT HISTORY FORM (GREEN FORM) SUBMISSION

## 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.

DATE OF BIRTH: 5/8/1943  
SOCIAL SECURITY NUMBER: 508-44-7644  
WHAT IS THE PRIMARY LANGUAGE SPOKEN IN YOUR HOME?  
 English  Spanish  Other  
NUMBER OF HOUSEHOLD MEMBERS:   
INSURANCE COVERAGE:  None  No HealthNet  Medicare  Private  
MEDICARE/DONORMEDICARE NUMBER: 00378811  
Race: (must be answered, choose all that apply)  
 (1) White  
 (2) Black or African American  
 (3) Asian  
 (4) Native Hawaiian or Other Pacific Islander  
 (5) American Indian or Alaska Native  
 (6) Other  
 (7) Unknown (please avoid using)  
Ethnicity: (must be answered)  
Are you of Hispanic origin?  Yes  No  
Highest grade of school completed (once one U.S. equivalent if educated in another country)  
How did you hear about the Show Me Healthy Women program? (please choose only one)  
 (1) Physician  (8) Health Care Provider  
 (2) Clinic  (9) Health Fair  
 (3) Television  (10) Health Coalition  
 (4) Radio  (11) Outreach Worker  
 (5) Printed Ad  (12) Relative/Friend  
 (6) Billboard  (13) Other Location  
 (7) Bus Sign  
What type of transportation did you use to get to your clinic appointment? (please choose only one)  
Date of last Pap Test: MM/DD/YYYY  
Date of Last Mammogram: MM/DD/YYYY  
Do you now smoke cigarettes?  
Name and telephone numbers of two people who can always reach you:  
Name: Home Phone With Area Code Work Phone  
First: Last: XXXXXXXXXX XXXXXXXXXX  
Last: XXXXXXXXXX XXXXXXXXXX



## 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 **always** 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.

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.

The screenshot shows the top portion of the Blue Screening Form. It includes a header with 'Add Patient' and 'No Patient' buttons. Below is a form with several sections:
 

- A dropdown menu for 'Additional Information Required?' with 'No' selected.
- A dropdown menu for 'CBE/WML' with 'Yes' selected.
- A section for 'FINDINGS' with radio buttons for 'Findings Present at CBE (checkbox only one)' and 'Work Home - Limits'.
- A section for 'Date of CBE' with a date field set to '7/15/2015' and a 'MM/DD/YYYY' label.
- A section for 'Previous Mammogram' with a dropdown menu set to 'No'.
- A section for 'Diagnosed Work up Planned' with a dropdown menu set to 'No'.

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).

### 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.

Pelvic section and PAP entered if completed during exam.

The screenshot shows the lower portion of the Blue Screening Form. It includes:
 

- A dropdown menu for 'Pelvic Exam W/O Additional Information Required?' with 'Yes' selected.
- A section for 'Pelvic Exam' with radio buttons for 'Normal', 'Abnormal', 'Cervical Cancer (Needs Annual Pap test)', 'No VA Present', and 'History for Gynecology Unknown'.
- A section for 'Date of Pelvic Exam' with a date field set to '7/15/2015' and a 'MM/DD/YYYY' label.
- A section for 'Previous PAP Test' with a dropdown menu set to 'Yes'.
- A section for 'Date of Last PAP Test' with a month field set to '9' and a year field set to '2014'.
- A section for 'Date of Molar Test' with a date field set to '7/15/2015' and a 'MM/DD/YYYY' label.

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”.*

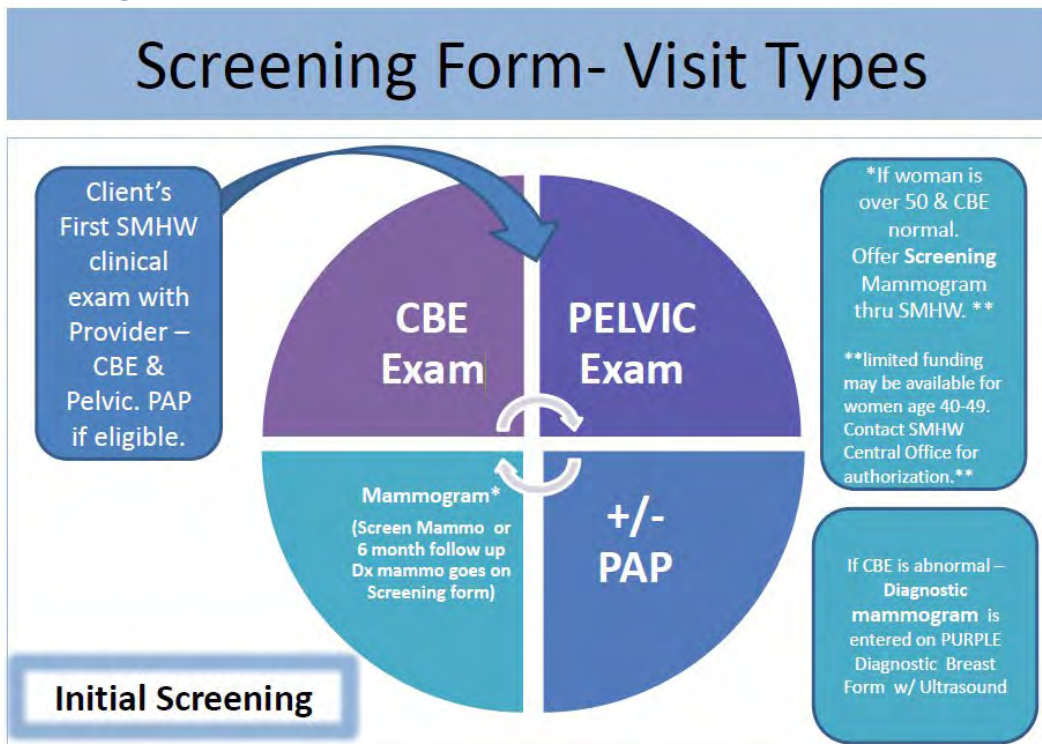
The screenshot shows a web-based form for a Pap test result. Key fields include:
 

- PERFORM PAP Test:** Yes
- USER OF LAST PAP Test:** none, 9, year 2014
- Date of TEST/PAP Test:** 7/15/2015
- Specimen Adequacy:** Satisfactory (selected), Unsatisfactory (Diect), Unspec
- HPV Test Result:** Negative
- Diagnosis (Reporting Provider):** Yes, 08/2015
- Comments:** COLPOSCOPY 11/2/2014 10/8/2014 RESULT TO MR. AS ANNUAL IS 3 WEEKS EARLIER THAN 10 MONTHS MINIMUM PER SMHW. ... OF CLAIMS-EV

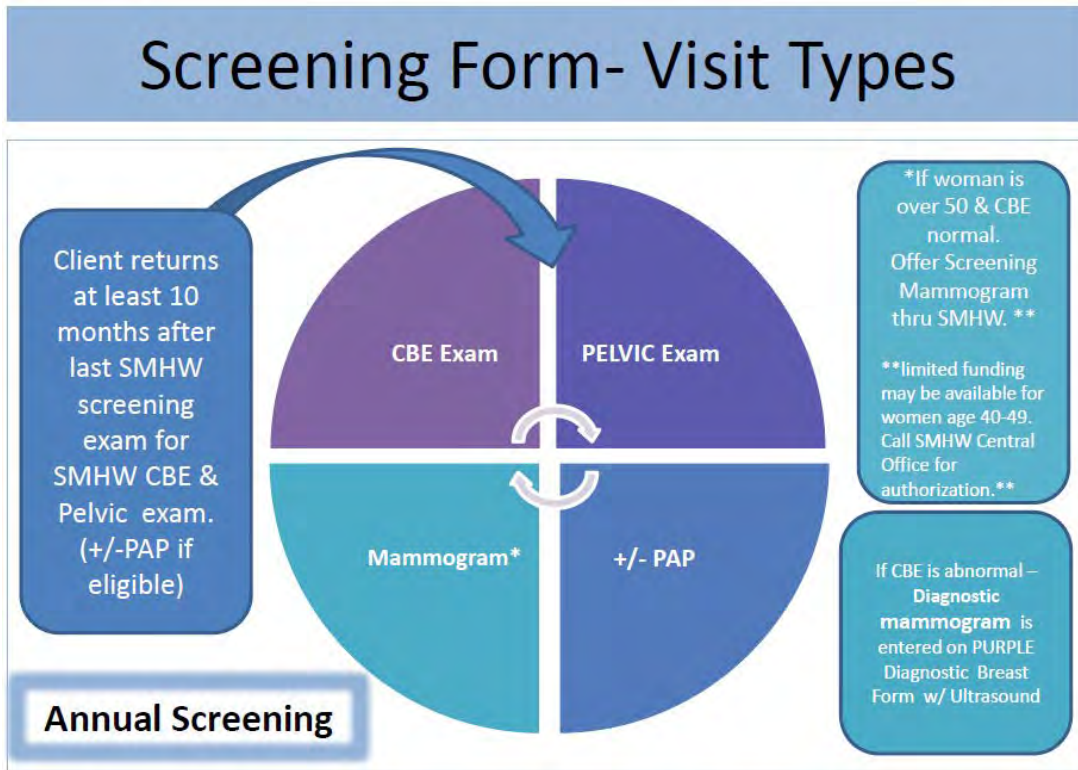
 A blue arrow labeled 'Comments:' points to the bottom section of the form.

## Blue Screening Form Visit Types

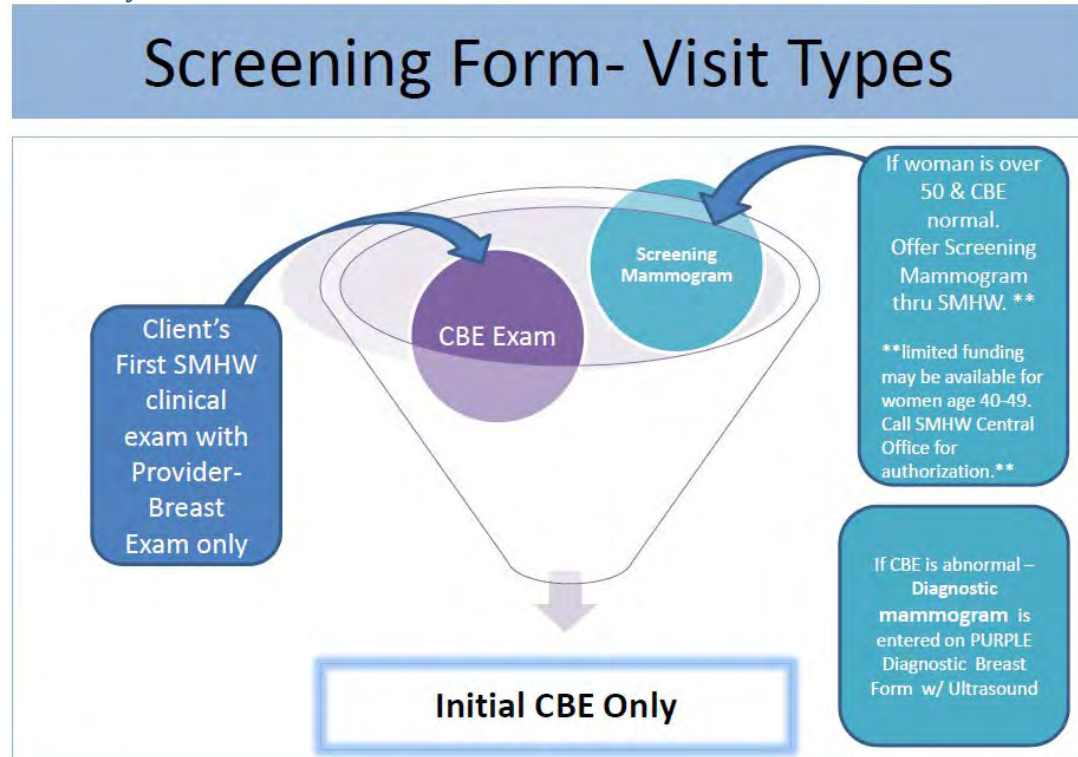
### Initial Screening



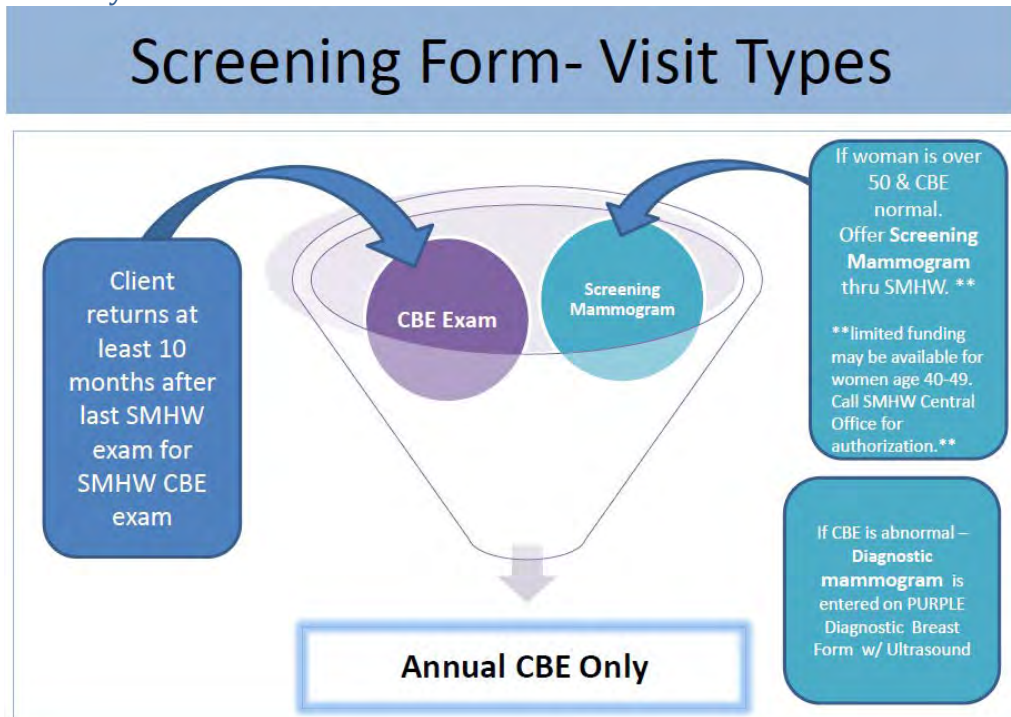
Annual Screening



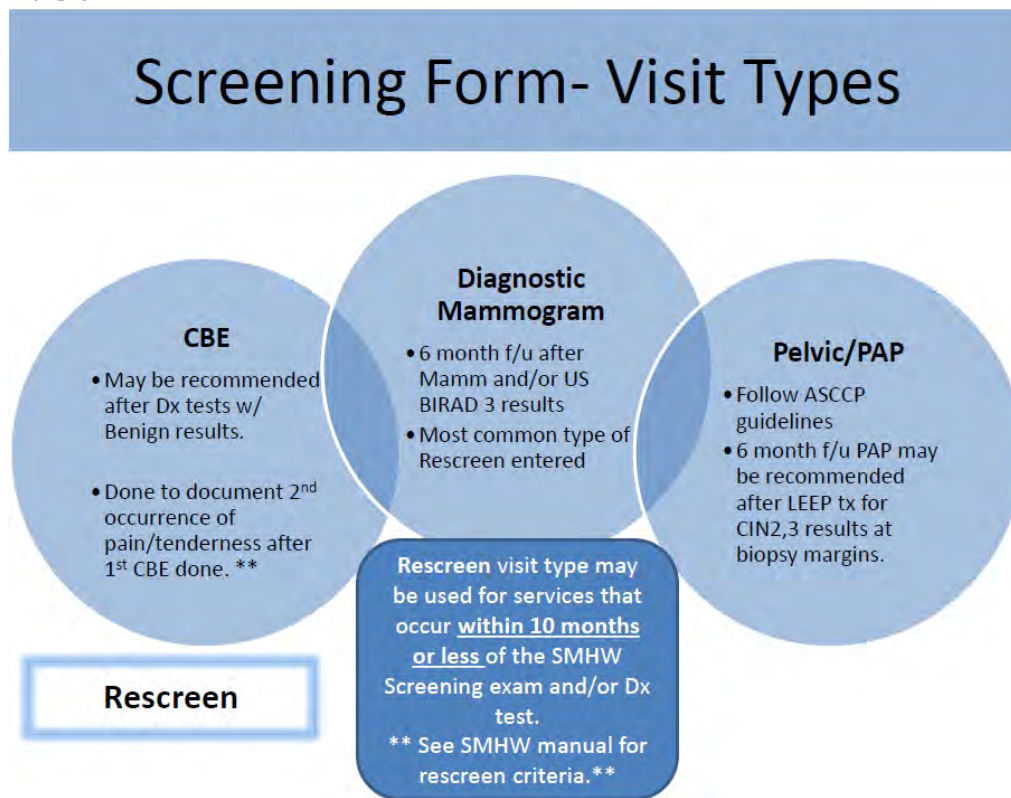
Initial CBE Only



Annual CBE Only



Rescreen Visit





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

A. PERSONAL DATA					
Name (Last, First, Middle Initial)		[REDACTED]			
Maiden Name		[REDACTED]			
Date of Birth		Social Security Number		Medicaid DCN/Medicare Number	
Age (Years): 35	[REDACTED]		[REDACTED]		
Date Form Received: 07/02/2014 MM/DD/YYYY			Initial	Visit Type	
			<input type="checkbox"/> Referral Fee		
Yes	Client Eligibility Verified	No	Insurance Coverage	[REDACTED]	
			Type of Medicare		
Height	ft	in	Weight	lbs	BMI
			Blood Pressure		
			1st Reading		Average
			2nd Reading		
B. CLINICAL BREAST EXAM RESULTS					<input checked="" type="checkbox"/> Reporting Only
Does client report any breast symptoms?		No	Additional Information Required if "YES" Selected		
CBE WNL		Yes	Additional Information Required if "NO" Selected		
Findings Present at CBE (check only one)					
<b>BENIGN FINDING:</b>					
<input checked="" type="radio"/> Within Normal Limits					
<input type="radio"/> 1) Benign finding (fibrosystic changes, diffuse lumpiness, clearly defined thickening, tenderness or nodularity)					
<small>SUSPICIOUS FOR CANCER (requires additional follow-up)</small>					
Date of CBE		05/07/2014		MM/DD/YYYY	
Rescreen Planned (less than 10 months)		No	[REDACTED]		
Diagnostic Work-up Planned (must be less than 60 days)		No	[REDACTED]		

C. MAMMOGRAM RESULTS

Clear

Reporting Only

(4) Mammogram not done. Patient only received CBE  
OR proceeded directly for other imaging or diagnostic workup

(1) Routine screening mammogram

(2) Mammogram performed to evaluate symptoms:

- Positive BSE
- Positive CBE
- Previous abnormal mammogram results (reporter)

(5) Cervical record only, mammogram not done

(8) Referred to Direct Biller for Mammogram

(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

Mammogram Provider Facility

Mammogram Ven

Previous Mammograms

Date of Last Mammogram

Date of This Mammogram

Type of Mammogram

- Screening
- Diagnostic
- Supplemental
- Biopsy

Clear

BIMM Mammogram Result/4 Response

LEP: R (B)T

Clear

NORMAL

- 1 Negative (Category 1)
- 2 Benign Finding (Category 2)
- 3 Possibly Benign (Category 3)

ABNORMAL

- 4 Suspicious Abnormality (Category 4)
- 5 Highly Suggestive of Malignancy (Category 5)

OTHER

- 6 Assessment Incomplete - Needs additional imaging evaluation (Category 6)
- 7 Assessment Incomplete - Film comparison required (Category 7)

(O)P: Results will require additional workup

Mammogram Result Comment

Rescreen Planned (less than 12 months)

Diagnostic Workup Planned (Must be less than 90 days)

Referred for Diagnostic Testing / Direct Biller

Date Next Annual Breast Cancer Screening

D. Cervical Cancer Screening Clear

- (5) Breast record only, cervical services not done
- (1) Routine Pap test
- (2) Patient under surveillance for previous abnormal (Rescreen)
- (4) Pap test not done. Patient proceeded directly for diagnostic workup or HPV test
- (6) Referred to Direct Biller for Pap and Pelvic
- (3) Abnormal Pap test done by non program provider (reporting only)

Referral Date: 05/21/2014

E. PELVIC EXAM RESULTS

Reporting Only

D2

Pelvic Exam WNL

Additional Information Required if 'NO' Selected

Yes ▾

Hysterectomy?

No ▾

- DenX/Screen
- DenX/Abn due to cervical cancer (needs annual Pap test)
- DenX/Presn
- Reason for hysterectomy (optional)

Date of Pelvic Exam

05/07/2014 MM/DD/YYYY

Reproductive Status

Premenopausal  Postmenopausal

Re biopsy Planned (less than 10 months)

No ▾

MM/DD/YYYY

Re biopsy Planned (More than 10 months)

No ▾

MM/DD/YYYY

F. PAP TEST RESULTS NOTE: Results with \* require additional follow-up.

Reporting Only

Previous PAP Test Yes

Date of Last PAP Test month 05 year 2013

Date of This PAP Test 05/07/2014 MM/DD/YYYY

Specimen Adequacy  Satisfactory

Clear

Unsatisfactory Due To:

Unknown

Specimen Type

Conventional Smear  Liquid Based Clear

Annual Pap due to previous treatment for cervical cancer

SMHV PAP Test Result (Select one)

NORMAL

(1) Negative for Intraepithelial Lesion or Malignancy

ABNORMAL

(2) Atypical Squamous Cells of Undetermined Significance (ASC-US) (May have HPV test)

Clear

(3) Lowgrade SIL (HPV/MM Dysplasia/CIN I)

(4) Atypical Squamous Cells cannot exclude HSIL (ASC-H) \*

(5) Highgrade SIL (with features suspicious for invasion/CIN II-III/CIS) \*

(6) Squamous Cell Cancer \*

(7) Atypical Glandular Cells (including atypical endocervical adenocarcinoma in situ and adenocarcinoma) \*

OTHER

(9) Other

Endocervical Cells Yes

HPV Profile: 05/07/2014 MM/DD/YYYY  Reporting Only

Clear

HPV Test Result

Positive(High Risk)

Rescreen Planned (less than 10 months) No

Diagnostic Work-up Planned (Must be less than 90 days) Yes 06/2014 MM/YYYY

Referred for Diagnostic Work-up / Direct Biller Physician / Facility Name

Date Next Annual Cervical Cancer Screening: MM/YYYY

COMMENTS Maximum length is 700 characters.

CLIENT REFERRED TO SMHW FOR COLPO ON 5/21/14 AFTER SHE TURNED 35 YEARS OLD ON 5/11/14. PAP WAS DONE THRU ANOTHER FUNDING SOURCE.

Override

## Screening From (Blue Form) Mammogram Only

Date Form Received: 5/28/2013 11:00:00 AM

Visit Type: **Annual**  Referral Fee

Client Eligibility Verified: **Yes** Insurance Coverage: **No**

Height:  ft  in Weight:  lbs BMI:  Blood Pressure:  /  Average  
 Fat Reading:  Red Reading:

**C. CLINICAL BREAST EXAM RESULTS**

Does client report any breast symptoms?  Additional Information Requested? **YES** Selected  
 CBE WNL:  Additional Information Requested? **NO** Selected  
 Date of CBE:  MM/DD/YYYY  
 Reexam Planned (less than 10 months):  No  
 Diagnostic/Workup Planned (Must be less than 90 days):  No

**D. MAMMOGRAM RESULTS**

(4) Mammogram not done. Patient only received CBE. OR preoperatively, for other imaging or diagnostic workup.  
 (1) Routine screening mammogram  
 (2) Mammogram performed to evaluate symptoms:  
 Positive CBE  
 Positive CSE  
 Previous positive mammogram results (ascertain)  
 (5) Cervical record only, mammogram not done  
 (6) Referred to Direct Biller for Mammogram  
 (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 Claim Referral for diagnosis:

Mammogram Provider Facility: **MERCY CH CHUB OREILLY CANCER CENTER**  Mammogram Unit  
 Previous Mammogram: **Yes**  
 Date of Last Mammogram: **month 05 year 2010**  
 Date of This Mammogram: **4/16/2013**  
 Type of Mammogram:  Screening  Diagnostic  Other  
 Conventional  Digital

Screening Mammogram Result (Check one):  
 LEFT RIGHT  
 subRoal:  1 Negative (Category 1)  2 Benign Finding (Category 2)  3 Probably Benign (Category 3)  4 Suspicious Abnormality (Category 4)\*  
 abnormal:  5 Highly Suspicious of Malignancy (Category 5)\*  
 OTHER:  6 Assessment Incomplete - Needs additional imaging evaluation (Category 6)\*  
 NOTE: Results with \* require additional followup.  
 11 Assessment Incomplete - Film comparison required (Category 11)

Mammogram Result Comment:

Reexam Planned (less than 10 months):  No  
 Diagnostic/Workup Planned (Must be less than 90 days):  No  
 Referred for Diagnostic Testing / Direct Biller:  physician / Facility Name:   
 Date Next Annual Screening: **04/2014**

**E. Cervical Cancer Screening**

(8) Breast record only, cervical services not done  (1) Routine Pap test  
 (2) Patient under surveillance for previous abnormal (Recurrent)  
 (4) Pap test not done. Patient co-managed already for diagnostic workup or HPV test.  
 (5) Referred to Direct Biller for Pap and Pelvic  
 (3) Abnormal Pap test done by non program provider (reporting only).  
 Referral Date:

**F. PELVIC EXAM RESULTS**

Pelvic Exam WNL:  Additional Information Requested? **NO** Selected  
 Reproductive Status:  Premenopausal  Postmenopausal  
 Reexam Planned (less than 10 months):   
 Diagnostic/Workup Planned (Must be less than 90 days):

**G. PAP TEST RESULTS** NOTE: Results with \* require additional followup.

**COMMENTS** (maximum length is 25 characters)

ENTERED BY DULCI ORR  
 5/31/13- PER EMAIL FROM D. ORR-FORDLAND, OV ALREADY PD. TRYING TO SUBMIT THIS FORM FOR MAMMOGRAM ONLY. EDIT FORM. DELETED DUPLICATE OV. PD MAMMO. MRR

Please Be Sure to Mark the "Reporting Only" Box in the Section When Not Requesting Reimbursement

Delete **Submit** Cancel

Open WV form for same client after submit

To enter a Mammogram alone:

- 1) Select Visit type: **Annual** (if mammogram follows a SMHW office visit) or **Rescreen** (if mammogram is 6 month follow up.) Complete *Client Eligibility Verified & Insurance Coverage* drop down boxes. Leave the rest of the info (ht, wt, etc) blank.
- 2) Skip section B
- 3) Go to Section C- Mammogram Results. Enter mammogram info & results.
- 4) Go to Section D- Select (5) *Breast record only, cervical services not done*.
- 5) Skip sections E & F
- 6) You may have to select – Post menopausal in the *Reproductive Status* (Section F) to get the form to submit. Otherwise...
- 7) Scroll to bottom of the blue form and enter any **Comments** needed.
- 8) Hit the **Submit** button.

## SHOW ME HEALTHY WOMEN BREAST FORM (PURPLE FORM) SUBMISSION

### Purple Breast Form

- Diagnostic mammogram after abnormal CBE or follow up to BIRAD 0 screening mammogram is entered on this form.
- Ultrasound results entered
- Biopsy results entered, if applicable. (most of the time, biopsy paid by BCCT & entered as "Reporting only").
- Final Dx/Work up Complete entered, 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 Breast Cancer.

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.

The screenshot shows a web-based form for breast cancer reporting. It has two main columns: 'Diagnostic Mammogram' and 'Final Biopsy Result'. The 'Diagnostic Mammogram' column has a date field set to 9/3/2015, a 'MAMMOGRAM' dropdown menu, and radio button options for 'Normal' (1-5) and 'Abnormal' (1-5). The 'Final Biopsy Result' column has a 'Final Biopsy Result' dropdown menu and radio button options for 'Normal' (1-5) and 'Abnormal' (1-5). At the bottom of the form, there are three buttons: 'Submit', 'Report Only', and 'Reporting Only'. The form is titled 'Diagnostic Mammogram' and 'Final Biopsy Result'.

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.

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.
- Colposcopy 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.

B. CERVICAL DIAGNOSTIC PROCEDURES		
Specialist Consultation	<input type="text"/> MM/DD/YYYY	<input type="checkbox"/> Reporting Only
Diagnostic Work-up Planned	<input type="radio"/> None <input type="radio"/> 0 - 50 Days <input type="radio"/> 61 - 90 Days	
Colposcopy without Biopsy	<input type="text"/> MM/DD/YYYY	<input type="checkbox"/> Reporting Only
Colposcopy	8/12/2015 MM/DD/YYYY	<input type="checkbox"/> Reporting Only
Polypectomy	<input type="text"/> MM/DD/YYYY	<input type="checkbox"/> Reporting Only
<input type="checkbox"/> Cervical Biopsy <input type="checkbox"/> Colposcopy inadequate, need further diagnostic <input type="radio"/> 1 Additional Cervical Biopsy		
<input checked="" type="checkbox"/> Endocervical Biopsy <input type="checkbox"/> Endometrial Biopsy (Can only be reimbursed with cervical biopsy) <input type="radio"/> 2 Additional Cervical Biopsies		

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 MM/DD/YYYY (Includes lost to follow-up, refused, and irreconcilable)
<b>Diagnostic results with (*) require treatment</b>	
D. CERVICAL TREATMENT	
Status of Treatment	
<input type="radio"/> Started <input type="radio"/> Pending <input type="radio"/> Lost to F/U (Describe in comment section) <input type="radio"/> Refused (Describe in comment section/Must have signed waiver) <input checked="" type="radio"/> Not Needed <input type="button" value="Clear"/>	
Types	
<input type="radio"/> Cryotherapy <input type="radio"/> Conization <input type="radio"/> Repeating 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.