2019 Apple Health (Medicaid)
Provider Form for Adult Members
Molina Rewards Program - Amazon.com Gift Cards

Provider Instructions

1. Please fill out this form and return to Molina, by fax at (800) 461-3234 or by email at MHW_QI_Interventions@MolinaHealthcare.com.
2. **Please keep a copy of this form in the member's chart for your records.**
3. Members may be eligible to receive an Amazon.com Gift Card.
4. Please submit claims with appropriate codes after completing each service. If claims are not received, medical records may be requested.
5. For services marked with an asterisk (*) below, please submit supporting medical records along with this form.
6. To see a HEDIS® Quick Reference Guide on codes for each measure visit: MolinaHealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx

Member Information

Member's Name: ______________________ DOB (MM/DD/YYYY): ______________________

ProviderOne Medicaid ID Number: ______________________ Molina Member ID Number: ______________________

Cell Phone Number: ______________________ Other Phone: ______________________

Email Address (Required): ______________________

Email address must be included for the member to obtain their rewards.

Provider Information

Provider Name: ______________________ Clinic Location and City: ______________________

Provider Phone Number: ______________________ NPI: ______________________

Provider Signature: ______________________ **Date** (MM/DD/YYYY)**:** ______________________

Vital Signs: BP ____________ Height ____________ Weight ____________ BMI Percentile ____________

Does member have hypertension? Yes_____ No _______

Prenatal Visit (PPC – Prenatal)*: For members who receive a prenatal visit during the first 3 months of their pregnancy, or within the first 42 days of joining Molina if they are a new member *(member may be eligible for a $100 reward, please submit this form along with a copy of the medical record documenting the visit).*

Date of Visit (MM/DD/YYYY): ______________________ Weeks pregnant at time of visit: ______________________

If visit to PCP, please note pregnancy diagnosis code: ______________________

Which of the following occurred during the visit? Check all that apply.

☐ Basic physical obstetrical exam including auscultation for fetal heart tone
☐ Pelvic exam with obstetric observations
☐ Measurement of fundus height
☐ Screening test in the form of an obstetric panel: hematocrit, differential WBC count, platelet count, hepB surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing
☐ TORCH antibody panel
☐ Rubella antibody test/titer with an Rh incompatibility blood typing
☐ Ultrasound of pregnant uterus
☐ Documentation of LMP ________ or EDD ________ or Gestational Age ________
AND one the following:
☐ Prenatal risk assessment and counseling
OR
☐ Complete obstetrical history

For questions, please call (425) 424-1100, ext. 141428, or email MHW_QI_Interventions@MolinaHealthcare.com.

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Postpartum Visit (PPC - Postpartum)*: For members who receive a postpartum visit between 21-56 days after they delivery their baby *(member may be eligible for a $50 reward, please submit this form along with a copy of the medical record documenting the visit).*

Date of Delivery (MM/DD/YYYY): ______________________________ Date of Visit (MM/DD/YYYY): ____________________

Which of the following occurred during the visit? Check all that apply.
☐ Pelvic Exam
☐ Evaluation of Weight, BP, Breasts, and Abdomen
☐ Notation of postpartum care in the chart (on date of visit)

Cervical Cancer Screening (CCS)*: For women ages 21-64 who receive a cervical cancer screening during the current year or 2 years prior, or members ages 30-64 who had co-testing (pap smear and an HPV test) during the current year or 4 years prior *(member may be eligible for a $25 reward, please submit this form along with a copy of the medical record documenting the visit).*

Pap Smear Date of Visit (MM/DD/YYYY): ________________________ Result: ______________________________________

If applicable - HPV Test Date of Visit (MM/DD/YYYY):______________ Result: ______________________________________

Diabetes Management

Does member have Diabetes? ☐ Yes - Date diagnosed (MM/DD/YYYY): ______________________________________
☐ No

Diabetes HbA1c Test (CDC – A1c <9)*: For diabetic members ages 18-75 who get tested for their HbA1c and have a result of less than 9 *(member may be eligible for a $25 reward, please submit this form along with a copy of the medical record documenting the visit).*

Most recent HbA1c Test Performed: ☐ Yes - Date (MM/DD/YYYY): ______________ Result: ______________________
☐ No

Diabetes Eye Exam (CDC – Eye Exam)*: For diabetic members ages 18-75 who get their yearly eye exam *(member may be eligible for a $25 reward, please submit this form along with a copy of the medical record documenting the visit).*

Retinal Eye Exam Performed: ☐Yes - Date(MM/DD/YYYY): ____
☐ No
Result (Required): ☐ Retinopathy ☐ No Retinopathy
Vision Care Provider Name: ____

Breast Cancer Screening (BCS): For women ages 50-74 who receive a mammogram anytime on or between October 1 two year prior and December 31 of the current year *(member may be eligible for a $25 reward).*

Has the member had a mammogram in the past 2 years?
☐ Yes - Date of most recent mammogram (MM/DD/YYYY): ____
☐ No

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