Healthy Connections

South Carolina Department of Health and Human Services

Application for Medicaid Family Planning Coverage

things to know

About this program

- This application is used to apply for Medicaid for Family Planning coverage only.
- Services include a comprehensive physical examination, some preventative health screenings, and family planning services, including birth control, permanent sterilization procedures, lab work, examinations and counseling. Coverage does not include treatment for other health conditions, prescriptions that are unrelated to family planning or Sexually Transmitted Infection (STI) treatment, or emergency hospital visits.
- If you would like to apply for full Medicaid benefits, please request a DHHS Form 3400, Application for Healthy Connections (Medicaid) by calling (800) 549-0820 or apply online at **SCDHHS.gov**.
- The Affordable Care Act requires most individuals to have health insurance coverage that meets minimum essential coverage. The Family Planning program does not meet minimum essential coverage. This means you may have to pay a tax penalty if you do not have other health insurance coverage. To learn more about health insurance coverage options or to see if you qualify for an exemption, visit www.healthcare.gov or call 1-800-318-2596.

What you may need to apply

- Social Security Number (or document numbers if a legal immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and how to get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to **SCDHHS.gov**.

What happens next?

Send your complete, signed application to the address in Step 5. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you. You'll get instructions on the next steps to complete your application for Family Planning. If you have questions, call 1-888-549-0820.

Who can use this application?

- Apply even if you already have health coverage. You could be eligible for lower-cost or free coverage.
- Certain qualifying immigrants can apply. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete the Authorized Representative Form (1282), which can be downloaded at **SCDHHS.gov**.

Get help with this application

- **Online: SCDHHS.gov**
- **Phone:** Call our Help Center at **1-888-549-0820**.
- **In person:** There may be counselors in your area who can help. **Visit our website** or call **1-888-549-0820** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-888-549-0820**.

NEED HELP WITH YOUR APPLICATION? Visit **SCDHHS.gov** or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-888-842-3620**.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: civilrights@scdhhs.gov.

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Language Services

If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).

si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).

أذا كانت لغتك الاساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجانا.اتصل على الرقم:

888-549-0280(رقم هاتف الصم والبكم 1-888-842-3620)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).

Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.

धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-549-0820 (TTY: 1-888-842-3620) पर कॉल कर।

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).

နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ် ကျိာ်အတ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၢ် နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် ှင့်အတူက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ် ဆိုပါ။

STEP 1

We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

Your Information

1. First name, Middle name, Last name and Suffix

2. Date of birth (mm/dd/yyyy)

3. Sex: ☐ Male ☐ Female

4. Social Security Number (SSN)

a. If you don't have a SSN, have you applied for one? ☐ YES ☐ NO
If no indicate the reason at question 24.

We need this if you want health coverage and have an SSN. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If you want help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-888-842-3620

5. Home address (Leave blank if you don't have one.)

6. Apartment or suite number

7. City

8. State

9. ZIP code

10. County

11. Mailing address (if different from home address)

12. Apartment or suite number

13. City

14. State

15. ZIP code

16. County

17. Phone number

18. Other phone number

19. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address:

20. What is your preferred spoken or written language (if not English)?

Is someone helping you fill out this application?

Complete the following section if you are filling out this form on behalf of the applicant.

Application start date (mm/dd/yyyy)

First name, Middle name, Last name, & Suffix

Organization Name (if applicable)

ID Number (if applicable)

NEED HELP WITH YOUR APPLICATION? Visit **SCDHHS.gov** or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-888-842-3620**.

STEP 1: Cont. (Continue with information about yourself)

21. Are you incarcerated? ☐ Yes ☐ No If YES, date incarcerated: _____

22. a. Are you a U.S. citizen? (Born in U.S.; child of U.S. citizen; or former alien now naturalized as a U.S. citizen) ☐ Yes ☐ No

b. Are you a U.S. national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No

23. **If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?** ☐ Yes ☐ No

If YES, fill in your document type and ID number below.

a. Immigration document type: _____

b. Document ID number: _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

24. If you have not applied for a Social Security Number, list the reason:

☐ Issued for non-work reasons only ☐ No SSN due to religious reasons ☐ Not eligbile for SSN

25. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

a. Was your household income the same during these 3 months as it is now? ☐ Yes ☐ No

If NO, enter your total monthly income for: Last Month: $_____ 2 Months Ago: $ _____ 3 Months Ago: $ _____

26. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)**

☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other:

27. **Race (OPTIONAL—check all that apply)**

☐ White ☐ Black/African-American ☐ American Indian or Alaska native ☐ Asian Indian ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Chinese ☐ Other: _____

Current income information

☐ **Employed** Start with question 28. ☐ **Not Employed** SKIP to question 34. ☐ **Self-Employed** SKIP to question 33.

CURRENT JOB 1:

28. Employer name and address _____

29. Employer phone number _____

30. Wages/tips (before taxes) $ _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

31. Average hours worked each week _____ 32. Start date _____

33. **If self-employed:** a. Type of work _____ b. Expected net income this month? _____

34. **OTHER INCOME:** Check all that apply, and give the amount and how often you get it (for example: pension or alimony income). **NOTE:** You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement acc'ts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing: $ _____ How often? _____

☐ Net rental/royalty: $ _____ How often? _____

☐ Other income:

☐ Type: _____ $ _____ How often? _____

☐ Type: _____ $ _____ How often? _____

35. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it. If you pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions: $ _____ How often? _____ Type: _____

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-888-842-3620**.

STEP 2 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you American Indian or Alaska Native?

☐ **If NO,** skip to Step 3.

☐ **YES. If YES,** ask for and complete SCDHHS Form 3400-Appendix B (American Indian or Alaska Native Family Member).

STEP 3 Your health coverage

Please answer these questions about your health coverage, if applicable.

Are you enrolled in health coverage now from the following? If available, please provide a copy of the insurance card.

☐ **YES.** If yes, check the type of coverage. ☐ **NO.**

☐ Medicaid

☐ CHIP

☐ Medicare

Claim number:

Date Medicare coverage started:

☐ TRICARE (Don't check if you have direct care of Line Of Duty)

☐ VA health care programs:

☐ Peace Corps:

☐ Employer insurance

Name of health insurance: _____

Policy number: _____ Start Date: _____

Is this COBRA coverage? ☐ Yes ☐ No

☐ Is this a retiree health plan? ☐ Yes ☐ No

☐ Other health insurance

Name of health insurance: _____

Policy number: _____ Start Date: _____

Is this a limited-time benefit plan (ex: a school accident policy)? ☐ Y ☐ N

STEP 4

Read and Sign. Please read the following rights and responsibilities. If you disagree with a statement, your eligibility for programs may be impacted. A signature is required to complete the application process and submit your application to the agency.

1. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by calling (888) 808-4238 or writing to the Civil Rights Division, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206.
2. I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and may not have to cooperate.
3. I assign and give my rights to any payments from a liable third party to the SCDHHS up to the payment amount that Healthy Connections has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from health insurance, legal settlements, or other third parties. I also understand that I have a duty to cooperate in identifying and providing information to assist Healthy Connections in pursuing third parties who may be liable to pay for care and services.
4. I understand that I must cooperate fully with state and federal workers if my case is reviewed. I also understand that, as a condition of eligibility, I must apply for and take steps to obtain any other benefits, including but not limited to annuities, pensions, retirement, disability and other benefits.
5. As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:
   - A person of any age who was a patient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
   - A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

   I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.
6. I know that I must tell SCDHHS within 10 days if any information I listed on this application changes and is different than what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.

7. The information I provide on this application and in future interaction with SCDHHS will be used to check my eligibility for help paying for health coverage, if I choose to apply. If the information I provide doesn't match electronic data, I may be asked to send proof. I know that, unless I specifically ask to be excluded, information collected will be securely stored in order to be sure that services provided to my family and me are sufficient and necessary.
8. If I think SCDHHS, the agency that administers Healthy Connections, the state's Medicaid program, has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair hearing. I must submit a written request for such a hearing to SCDHHS. I know that I may represent myself or be represented by someone other than myself.
9. I know that personal health information I provide or that is later gathered by SCDHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will receive a Notice of Privacy Practices along with my Healthy Connections Card(s).

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here, as long as you have provided the information required on DHHS Form 1282 - Authorized Representative.
By signing, I state that I have read and agree to the rights and responsibilities stated on this application.

Signature **Date (mm/dd/yyyy)**

Please print this form, then sign it on the line above before submitting.

Permission to Release Information

Is there anyone that you would like us to share information with about your application?

By completing this section, you can give permission for the following person to receive information about your application/ case, but they won't have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission to release information about this application to this additional person or organization.

Name of person/organization		Phone	
Address	City	State	ZIP
Unit (if applicable)	ID Number (if applicable)		

STEP 5 Mail the completed application.

Mail your signed application to:

SCDHHS - Central Mail
PO Box 100101
Columbia SC 29202-3101

OR Fax your application to:

(888) 820-1204

If you want to register to vote, you can complete a voter registration form at **scvotes.org**.

Family Planning

Family Planning is available to individuals (men and women) whose annual family income is at or below 194% of the Federal Poverty Level (FPL).

Eligibility:

Individuals who may be eligible for Family Planning must:

- Be a South Carolina resident
- Be a U.S. citizen or Lawful Permanent Resident Alien
- Have a Social Security Number or verify an application for one
- Be ineligible for full Medicaid coverage under any other eligibility category

Income Limit:

Family Size	Eff. 03/01/2018	
	Monthly Income	**Annual Income**
1	1,962.63	23,551.60
2	2,661.03	31,932.40
3	3,359.43	40,313.20
4	4,057.83	48,694.00
5	4,756.23	57,074.80
6	5,454.63	65,455.60
7	6,153.03	73,836.40
8	6,851.43	82,217.20
Each Additional Member	698.40	8,380.80

Benefits:

Family Planning is a limited benefit program, which provides coverage for preventive health care, family planning services and family planning-related services. This program does not meet the standard for Minimum Essential Coverage under the Affordable Care Act. This means you may have to pay a tax penalty if you do not have other health insurance coverage. You may, however, still be eligible for federal programs that will help you pay for insurance through tax subsidies. To learn more about health insurance coverage options or qualifying for an exemption, visit www.healthcare.gov or call 1-800-318-2596.

To Apply:

Apply online or complete the following form and submit it to your local county office

- Family Planning Application

Eau Claire Cooperative Health Centers, Inc.

LIMITED MEDICAID FOR ALL UNINSURED (WITHOUT INSURANCE) OR FULL MEDICAID

The Healthy Connections/HOP Team needs your help identifying ECCHC Uninsured patients that may qualify for the Family Planning Medicaid. HCCU/FP (Limited Medicaid) is available to individuals (men and women) whose annual income is at or below **194% of the Federal Poverty** Level.

We now have a Family Planning Application that is short and simple to complete for a one (1) member household. ATTACHED **(DHHS Form 400)**

Income Limit: Effective 03/01/2018

FAMILY SIZE	MONTHLY INCOME	ANNUAL INCOME
1	$1962.63	$23,551.60

Once the patient is determined **ELIGIBLE FOR HC CHECKUP: FAMILY PLAN, PHYS EXAM, PREV,** we will schedule the **Healthy Connections Checkup Exam.**

If the patient is diagnosed with a Chronic Disease and is GSP Level A, we will assign the HOP status and note this in the system. The patient will pay $10.00 Co-Pay when seeing their Primary Care Provider. **($10 reduction is for GSP Level-A patients only) HOP expiration is the same as GSP.**

Diagnosed Chronic Disease Codes

1	Asthma	6	End Stage Renal Disease
2	Behavioral Health	7	Heart Disease
3	Cardiovascular Disease	8	HIV
4	COPD	9	Hypertension
5	Diabetes	10	Sickle Cell Anemia

- **HCCU- Healthy Connections Checkup**
- **HCCU/FP- Healthy Connections/Family Planning (Limited Medicaid)**
- **HOP- Healthy Outcome Program** Chronic (desease

If you have any questions, please call:
Lorgean Graham, Healthy Connections Coordinator at (803) 260-8078
Sharon Sweat, HOP Enrollment Specialist at (803) 457-0113

Ends- March-

Healthy Connections Check-Up

We've Got You Covered!

What is HCCU?

- A free limited benefit Medicaid program;
- Available to Men and Women ages 19 to 64;
- Provides coverage for complete physical exam and health screenings;
- Provides referral for low cost treatment of chronic disease; and
- Provides free family planning services.

How do I enroll?

Call us today at (803) 260-8078 for an appointment with the HCCU Program Coordinator

Eau Claire Cooperative Health Center
People in Care do better.

3800 N. Main St., Suite D, Columbia, SC 29033

Eau Claire Cooperative Health Center
People in Care do better.

Lorgean Graham
Healthy Connections Coordinator

3800 North Main Street, Suite D
Columbia, SC 29203
Website: www.ecchc.org

Cell: (803) 260-8078
Fax: (803) 753-5857
Email: lgraham@ecchc.org

Eau Claire Cooperative Health Center
People in Care do better.

Sharon Sweat
Healthy Outcomes Enrollment Specialist

3800 North Main Street, Suite D
Columbia, SC 29203
www.ecchc.org

Cell Phone: (803) 457-0113
Fax: (803) 753-5857
Email: ssweat@ecchc.org

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Referral Instructions (Cont'd.)

5. If referring a patient for any **other condition or problem**, use modifier **P5**

Referral Instructions for Family Planning Providers who DO offer free or subsidized care to uninsured individuals (*examples*: FQHCs, hybrid clinics, RHCs, subsidized hospital clinics, etc.)

Providers that offer free or subsidized care to uninsured individuals should schedule follow-up visits with Family Planning beneficiaries when a problem or condition is identified during or after the physical examination or family planning visit. This "self-referral" activity is captured in the Encounter rate for the physical examination or family planning visit. However, for data collection and monitoring purposes, providers who fall into this category should include the referral code and appropriate modifiers listed above as a separate line on the Encounter claim form (these codes will bill to $0.00). The referral codes and accompanying modifiers will provide important data to SCDHHS regarding the utilization of follow-up care among the Family Planning population.

Note: Uninsured Family Planning patients will be responsible for any fees associated with follow-up visits. As Family Planning beneficiaries are considered uninsured for purposes of follow-up care, all visits should follow the provider's established policies and procedures for treating uninsured patients.

Referral Instructions for Family Planning Providers who refer patients for additional, preventive screenings

1. If you are a provider that performs a physical examination for a Family Planning beneficiary and are unable to perform certain preventive health screenings (examples include mammography, colonoscopy, AAA screening, and lung cancer screening using computerized tomography), you should refer the patient to a provider who is able to perform these screenings.
2. Providers are not allowed to submit a referral claim for this type of referral.

Covered Contraceptive Supplies and Services

The Family Planning Program provides coverage for contraceptive supplies (for example, birth control pills or male condoms) and contraceptive services such as an injections, IUD, Essure, or sterilization. Please refer to Section 4 of this manual for an approved list of procedure codes and drugs. When billing for contraceptive services and supplies, all claims must bill using a relevant Family Planning diagnosis code.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Biennial Physical Examination (Cont'd.)

- Age, gender and risk appropriate preventive health screenings, according to the United States Preventive Services Task Force Recommendations (Grade A & B only)

For more information on these recommendations, visit http://www.uspreventiveservicestaskforce.org.

USPSTF Grade A & B Recommendations as of August 1, 2014

Description	Appropriate for the following Family Planning Beneficiaries	Allowable Codes	Required Modifier	Provider Type Requirements	Notes
Age and Risk-Appropriate Screenings for the Following: • Alcohol Misuse • BRCA Screening Questions • Depression • Intimate Partner Violence • Obesity • Tobacco Use Low-Intensity Counseling for the Following: • Healthy Diet • Skin Cancer Prevention	• All adults	96150 96151 96152	FP	NP, PA or Physician	Must occur during physical exam
Cholesterol Abnormalities Screening	• Men ages 35+ • Men ages 20-35 if at increased risk for coronary heart disease • Women ages 20+ if at increased risk for coronary heart disease	80061 82465 83718	FP	NP, PA or Physician	Must occur during physical exam
Diabetes Screening	• Asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg	82947 82950 82951	FP	NP, PA or Physician	Must occur during physical exam
Hepatitis C Virus Infection Screening	• All adults at high risk for virus infection • One-time screening for all adults born between 1945-1965	86803 86804	FP	NP, PA or Physician	Must occur during physical exam
Breast Cancer Screening (Mammography)	• Women ages 50-74	77067 77066	FP	Physician Only	Can occur outside physical exam
Abdominal Aortic Aneurysm Screening	• Men ages 65-75 who have ever smoked	76706	FP	Physician Only	Can occur outside physical exam
Colorectal Cancer Screening	• Men and Women ages 50-75	45331 45378 82270 82274 88305 G0105	FP	Physician Only	Can occur outside physical exam
Lung Cancer Screening for Smokers	• **Adults ages 55 - 80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years**	71250	FP	Physician Only	Can occur outside physical exam

2014 Preventive Health Guidelines for Adult Men (USPSTF)

Screening / Counseling / Tests	Cover in Initial Visit	Cover in Annual Visit	Recognized by CMS as Family Planning?	19-39 Years	40-49 Years	50-64 Years	65+ Years
Complete / update patient history	✓	✓	Yes				
Height and weight (BMI), blood pressure	✓	✓	Yes				
Alcohol misuse screening and counseling	✓		Yes				
HIV screening	✓	If Increased Risk	Yes				
STI (including HIV) counseling	✓	✓	Yes				
Syphilis screening	✓	If Increased Risk	Yes				
Abdominal Aortic Aneurysm screening	One-Time		No				
Cholesterol abnormalities screening	✓	If Increased Risk	No				
Colorectal cancer screening	✓	Every 3-10 Yrs	No				
Depression screening	✓	✓	No				
Diabetes screening	✓	Every 3 Yrs	No				
Healthy Diet counseling	Ongoing		No				
Hepatitis C virus infection screening	✓	If Increased Risk	No				
Lung Cancer screening for smokers	✓	✓	No				
Obesity screening and counseling	✓	✓	No				
Skin cancer behavior counseling	✓	✓	No				
Tobacco use counseling and interventions	✓	✓	No				

Source- USPSTF A and B Recommendations: U.S. Preventive Services Task Force (http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm) and CDC 2014 Recommended Immunizations for adults (http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule-easy-read.pdf)