											;	STAT	TE O	F CC	DLORADO DEF	ARTMEN	T OF H	EALTH			ANCING
EDG	. D. T	. 61	A 18/																INVOICE/PAT. ACCT	NUMBER	
EPSDT CLAIM																					
1. CLIENT NAME (LAST, FIRST, M.I.)														2.	CLIENT ID NUMBER			3. DATE O		4. SEX	
																		MO	DAY YR	м	F
5. SCREENING														7			6.	OTHER INSU	JRANCE	•	
N = PERFORMED, NORMAL R = PERFORMED, REFERRED														1	OTHER INSURANCE?		☐ YES	· 🗆	NO		
A = PERFORMED, ABNORMAL LEAVE BLANK IF NOT PERFORMED.															INSURANCE PAID / D	ENIED	PAI		DENIED		
T = PER	FORME	ORMED, TREATED													DATE INSURANCE PA		20				
NO.		SCREENING ITEMS RESU										RES	SULTS		INSURANCE COMPAI	IY NAME/ADDRES	55				
01	_	MEDICAL HISTORY OBTAINED?																			
02	PHYS	PHYSICAL EXAMINATION?  ASSESSMENTS PERFORMED													INSURANCE POLICY	NUMBER					
03	VISIO	ASSESSMENTS PERFORMED VISION													INSURANCE GROUP	NUMBER					
04	HEA	HEARING																			
05	-	DENTAL													POLICYHOLDER NAME / ADDRESS						
06 07	+	DEVELOPMENTAL (PHYS. GROWTH/EMOTIONAL DEV./LEARNING) NUTRITIONAL/GASTROINTESTINAL																			
08	_			RESPIRATOR										$\dashv$							
09	GEN	ITAL/UR	INARY T	RACT											EMPLOYER NAME						
10	_	ETES												4							
11	₩	JNIZATI												-							
13	1	ER SCR												1							
	H			LAB TE	STS P	PERF	ORMI	ED						Ħ	7. DIAGNOSIS I	:D-9-CM		DESCRI	PTION		
01	HGB	/HCT												٦.	1/11/11/1						
02	1	IALYSIS												1							
03		LE CELI												1		<u> </u>					
04														-		<u> </u>					
05		BLOOD LEAD													4 1 1 1 1	J					
06	-	TB OTHER LAB													IN COLUMN 13, R	LATE DIAGNOSIS	S TO PROCE	DURE BY REF	ERENCE NUMBERS 1, 2,	3, OR 4	
8. LINE		DATE		10. PLACE OF	11.	PR	ROCED	URE		12. MOE	IFIER		DIAGN( RELATE		14. UNITS 15. OF CHARGES				16. COMMENTS		
		SERVICE OF PROCEDURE MO DAY YR SERVICE CODES							1 2			PS		SERVICE							
01							1	Ī													
02						l	l	l	l												
						_	<del>                                     </del>	ļ	<u> </u>									1			
03													<u> </u>	_							
04																					
05						I	I	l													
		l			H	<u>                                       </u>	<u>.                                    </u>	<u>.                                    </u>	<u> </u>					<u> </u>				<del>i</del>			
06														<u> </u>				<u> </u>			
07														<u> </u>				<u> </u>			
08		Ī				l	1	Ì	1					Ì							
		<u> </u>				<del>                                     </del>	<del>                                     </del>	<u> </u> 	! 												
09							ļ						<u> </u>	<u> </u>				-			
10									Ļ				<u> </u>			_					
17. NAM	17. NAME PHYSICIAN OR AGENCY DIAGNOSIS RELATED: RELATE DIAG												LATE D	IAGNOS	SIS IN FIELD 7 TO	21. TOTAL C	HARGES	[ ]	24. RENDERING PROVI	DER ID	
													NG TO I	NUMBER	ERS 1, 2, 3, OR 4						
									18	. BILLIN	G PROV	ider id				22. INS AMO	I INT PAID	1	25. REFERRING PROVI	DER ID	
																ZZ. ING AWO	JOHN PAID		LO. INCI LIMMING FINOVII	טבוייוט	
19. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE SIDE)															20. DATE SIGNE	23. NET CHA	RGE		26. SUPERVISING PRO	VIDER ID	
															1						
F05::	4 4 6 6	10 /55	1 0/00															<u> </u>			
FORM :	# 1001	ιၓ (RE	v. 9/98)	)																	