SAMPLE OVP COUNSEL

OREGON CLINIC VISIT RECORD

A. LAST NAME Smith B. FIRST NAME Bob C. M.I.

D. SOC. SEC. NO. E. CCare NO.

Items A-E only required for CCare Clients

1 SERVICE SITE NUMBER 1 2 3 4 5 6 7

2 CLIENT NUMBER 8 9 1 0 1 1 1 2 1

3 DATE OF VISIT MO. 0 1 DAY 0 2 YR. 2 0 1 5

4 DATE OF BIRTH MO. 0 6 DAY 1 5 YR. 1 9 6 0

5 GENDER ☐ 1 - Female ☐ 2 - Male

6 ETHNICITY ☐ 6 - Hispanic or Latino ☐ 9 - Not Hispanic or Latino

6a RACE (Mark All That Apply)
☐ 1 - White ☐ 3 - American Indian ☐ 5 - Asian ☐ 6 - Other
☐ 2 - Black/Afr. Amer. ☐ 4 - Alaska Native ☐ 7 - Unknown/Not Reported ☐ 8 - Native Hawaiian/Pac. Isl.

7. ADDITIONAL DEMOGRAPHIC (Check if Applicable)
☐ 5 - Limited English Proficiency

7a. CLIENT'S TEST DATES - Females Only
1 - Last Chlamydia (≤ 24) ☐ 1 Never ☐ 2 Unk. 3 Date MO. YR.
2 - Last Pap (≥ 21) ☐ 1 Never ☐ 2 Unk. 3 Date MO. YR.

8 ZIP CODE

9 ASSIGNED SOURCE OF PAYMENT (Check one)
☐ 01 - No Charge ☐ 04 - Private Insurance ☐ 07 - Other
☐ 02 - Title XIX (OHP) ☐ 05 - Full Fee ☐ 10 - Non-CCare Visit/ CCare Supply*
☐ 08 - CCare* ☐ 06 - Partial Fee ☒ 11 - OVP
☐ 03 - WA Take Charge
*Complete top section and 17 for CCare

9A. DIAGNOSIS CODE (Complete if Question 9 is 8) V25.

9B WILL INSURANCE BE BILLED FOR THIS VISIT?
(Complete if Question 9 is 8 or 10). ☐ 1- No ☐ 2- Yes (Complete 17A.)

9C. SPECIAL CONFIDENTIALITY NEEDS ☐ 1-Yes

18 CLIENT INSURANCE STATUS (check one)
(Principal Health Insurance covering primary care)
☐ 1 - Public Health Insurance ☐ 3 - Uninsured
☐ 2 - Private Health Insurance ☐ 4 - Unknown

10 INCOME AND FAMILY SIZE
a. What is your monthly family income? AMOUNT
b. How many people are in your family, that is, the number supported by this income? NUMBER

11. HEALTH INS. ENROLLMENT ASSISTANCE
☐ 1 - Onsite ☐ 2 - Referral

12 PURPOSE OF VISIT (Check One)
☐ 1 - First Annual Exam ☐ 5 - Pregnancy Test Visit
☐ 2 - Return Annual Exam ☐ 6 - Supply Only-Mailed (CCare Only)
☐ 3 - Other Medical ☐ 9 - Supply Only Visit (CCare Only)
☒ 4 - Counseling Only ☐ 8 - Vasectomy Referral (w/OVP SOP)

13A. MEDICAL SERVICES (Check all Applicable)

Exam & Lab Services
☐ 02 - Blood Pressure
☐ 03 - Height/Weight
☐ 04 - Thyroid Exam
☐ 05 - Heart/Lung Auscultation
☐ 06 - Breast Exam
☐ 07 - Abdominal Exam
☐ 08 - Extremities
☐ 09 - Bimanual/Speculum Pelvic Exam
☐ 23 - Hgb / Hct
☐ 24 - Urine Dip Strip/Urinalysis
☐ 25 - Pap Test Conventional
☐ 26 - Pap Test Liquid-Based
☐ 27 - Colposcopy
☐ 34 - Immunization
☐ 42 - Male Genitalia Exam
☐ 49 - Colo-Rectal Cancer Screening
☐ 36 - Other Lab or Exam
☐ 37 - No Lab or Exam

Contraceptive Related Services
☐ 17 - Diaphragm / Cap Fit
☐ 19 - IUD/IUS Insert
☐ 20 - Sterilization Procedure
☐ 38 - Hormone Implant In
☐ 39 - Hormone Implant Out
☐ 40 - Hormonal Injection
☐ 48 - EC-Immediate Need
☐ 46 - EC-Future Need
☐ 22 - IUD/IUS Removal
☐ 18 - Vasectomy Referral Fee

Pregnancy Related Services
☐ 21 - Post Pregnancy Exam
☐ 31 - Serum Pregnancy Test
☐ 32 - Negative Pregnancy Test
☐ 33 - Positive Pregnancy Test
☐ 35 - Infertility Screening

13A. CONT. MEDICAL SERVICES (Check all Applicable)

STD Related Services
☐ 11 - Vaginitis/Urethritis/Eval/Dx
☐ 12 - Vaginitis/Urethritis/Eval/Rx
☐ 29 - Chlamydia Test
☐ 13 - Chlamydia Treatment
☐ 14 - Chlamydia Presumptive Rx
☐ 15 - Wart Treatment
☐ 16 - Herpes Test
☐ 28 - Gonorrhea Test
☐ 30 - Wet Mount
☐ 43 - HIV Test Standard
☐ 44 - HIV Test Rapid
☐ 47 - VDRL/RPR
☐ 50 - HPV Test

14A COUNSELING EDUCATION PROVIDED (Check all Applicable)
☐ 01 - Contraceptive ☐ 09 - STD/HIV Prevention ☐ 18 - Relationship Safety
☐ 02 - Fertility Aware Mthd ☐ 10 - HIV Pre & Post
☒ 03 - Sterilization ☐ 16 - Abnormal Pap ☐ 12 - Nutrition
☐ 04 - Infertility ☐ 19 - BSE ☐ 05 - Tobacco
☐ 08 - Preconception ☐ 20 - TSE ☐ 06 - Substance Abuse
☐ 13 - Abstinence ☐ 15 - Crisis
☐ 07 - Pregnancy Options ☐ 17 - Encourage Parental/Family Involvement

19. PREGNANCY INTENTION SCREENING
☐ 1 - Yes, Near Future ☐ 3 - Unsure
☐ 2 - No, Maybe Later ☐ 4 - Never

13B.14B. PROVIDER OF MEDICAL SERVICES/COUNSELING/EDUCATION SERVICES (Mark all that Apply)
☐ 1 - Physicians
☐ 2 - Physician Assistants, Nurse Practitioners, Certified Nurse Midwives
☐ 3 - RNs, LPNs
☐ 4 - Other service providers, health educators, social workers, clinic aides and lab technicians.

15A PRIMARY CONTRACEPTIVE METHOD
(Complete before and after blocks)

HIGHLY EFFECTIVE
14 - Male Sterilization
01 - Female Sterilization
11 - Hormone Implant
15 - IUS
03 - IUD
22 - LAM

MODERATELY EFFECTIVE
16 - Hormonal Injection
02 - Oral Contraceptives
17 - Hormonal Patch
18 - Vaginal Ring
04 - Diaphragm/Cap

LESS EFFECTIVE
06 - Male Condom
19 - Female Condom
21 - Contraceptive Sponge
20 - Withdrawal
08 - NFP/FAM
07 - Spermicide

OTHER
09 - Other Method
13 - Abstinence
10 - None

BEFORE VISIT AFTER VISIT

15B. IF NONE AT THE END OF THIS VISIT, GIVE REASON.
Pregnant ☐ 1 - Planned ☐ 8 - Unplanned ☐ 3 - Seeking Pregnancy
☐ 6 - Not Sexually Active ☐ 7 - Other

16. REFERRAL INFORMATION (Check all Applicable)
☐ 02 - High Risk Pregnancy ☐ 05 - Sterilization ☐ 10 - Social Sevices
☐ 15 - Adoption ☐ 06 - Infertility ☐ 09 - Nutrition
☐ 03 - Abortion ☐ 07 - NFP/FAM ☐ 13 - Substance Abuse
☐ 01 - Prenatal ☐ 04 - STD ☐ 14 - Abuse/Violence
☐ 16 - Breast Evaluation ☐ 17 - Colposcopy ☐ 11 - None
☐ 12 - Mammography or U.S. ☐ 08 - Other Medical

17. MEDICAID BILLING (Complete top section for CCare)

Supplies Billed	Qty.	Unit Price	Supplies Billed	Qty.	Unit Price
01-Orals			07-Condoms, Male		
16-EC			08-Condoms, Fem.		
14-Patch			12-Cervical Cap		
15-Mirena IUD			17-Ring		
03-Copper IUD			18-Sponge		
04-Depo Provera			19-Subdermal Implants		
05-Diaphragm			20-Cycle Beads		
06-Spermicide			21-Skyla IUS		

17A. THIRD PARTY RESOURCE CODES
(Complete if client has other insurance coverage.)
1 - Explanation Code
2 - Other Insurance Paid

SAMPLE OVP REFERRAL FEE

OREGON CLINIC VISIT RECORD

A. LAST NAME Smith B. FIRST NAME Bob C. M.I.

D. SOC. SEC. NO. E. CCare NO.

Items A-E only required for CCare Clients

1. SERVICE SITE NUMBER 1 2 3 4 5 6 7

2. CLIENT NUMBER 8 9 1 0 1 1 1 2 1

3. DATE OF VISIT MO. 0 1 DAY 0 3 YR. 2 0 1 5

4. DATE OF BIRTH MO. 0 6 DAY 1 5 YR. 1 9 6 0

5. GENDER ☐ 1 - Female ☐ 2 - Male

6. ETHNICITY ☐ 6 - Hispanic or Latino ☐ 9 - Not Hispanic or Latino

6a. RACE (Mark All That Apply)
☐ 1 - White ☐ 3 - American Indian ☐ 5 - Asian ☐ 6 - Other
☐ 2 - Black/Afr. Amer. ☐ 4 - Alaska Native ☐ 7 - Unknown/Not Reported ☐ 8 - Native Hawaiian/Pac. Isl.

7. ADDITIONAL DEMOGRAPHIC (Check if Applicable)
☐ 5 - Limited English Proficiency

7a. CLIENT'S TEST DATES - Females Only
1 - Last Chlamydia (≤ 24) ☐ 1 Never ☐ 2 Unk. 3 Date MO. YR.
2 - Last Pap (≥ 21) ☐ 1 Never ☐ 2 Unk. 3 Date MO. YR.

8. ZIP CODE

9. ASSIGNED SOURCE OF PAYMENT (Check one)
☐ 01 - No Charge ☐ 04 - Private Insurance ☐ 07 - Other
☐ 02 - Title XIX (OHP) ☐ 05 - Full Fee ☐ 10 - Non-CCare Visit/ CCare Supply*
☐ 08 - CCare* ☐ 06 - Partial Fee ☒ 11 - OVP
☐ 03 - WA Take Charge
*Complete top section and 17 for CCare

9A. DIAGNOSIS CODE (Complete if Question 9 is 8) V25.

9B. WILL INSURANCE BE BILLED FOR THIS VISIT?
(Complete if Question 9 is 8 or 10). ☐ 1- No ☐ 2- Yes (Complete 17A.)

9C. SPECIAL CONFIDENTIALITY NEEDS ☐ 1-Yes

18. CLIENT INSURANCE STATUS (check one)
(Principal Health Insurance covering primary care)
☐ 1 - Public Health Insurance ☐ 3 - Uninsured
☐ 2 - Private Health Insurance ☐ 4 - Unknown

10. INCOME AND FAMILY SIZE
a. What is your monthly family income? AMOUNT
b. How many people are in your family, that is, the number supported by this income? NUMBER

11. HEALTH INS. ENROLLMENT ASSISTANCE
☐ 1 - Onsite ☐ 2 - Referral

12. PURPOSE OF VISIT (Check One)
☐ 1 - First Annual Exam ☐ 5 - Pregnancy Test Visit
☐ 2 - Return Annual Exam ☐ 6 - Supply Only-Mailed (CCare Only)
☐ 3 - Other Medical ☐ 9 - Supply Only Visit (CCare Only)
☐ 4 - Counseling Only ☒ 8 - Vasectomy Referral (w/OVP SOP)

13A. MEDICAL SERVICES (Check all Applicable)

Exam & Lab Services
☐ 02 - Blood Pressure ☐ 24 - Urine Dip Strip/Urinalysis
☐ 03 - Height/Weight ☐ 25 - Pap Test Conventional
☐ 04 - Thyroid Exam ☐ 26 - Pap Test Liquid-Based
☐ 05 - Heart/Lung Auscultation ☐ 27 - Colposcopy
☐ 06 - Breast Exam ☐ 34 - Immunization
☐ 07 - Abdominal Exam ☐ 42 - Male Genitalia Exam
☐ 08 - Extremities ☐ 49 - Colo-Rectal Cancer Screening
☐ 09 - Bimanual/Speculum Pelvic Exam ☐ 36 - Other Lab or Exam
☐ 23 - Hgb / Hct ☐ 37 - No Lab or Exam

Contraceptive Related Services
☐ 17 - Diaphragm / Cap Fit ☐ 40 - Hormonal Injection
☐ 19 - IUD/IUS Insert ☐ 48 - EC-Immediate Need
☐ 20 - Sterilization Procedure ☐ 46 - EC-Future Need
☐ 38 - Hormone Implant In ☐ 22 - IUD/IUS Removal
☐ 39 - Hormone Implant Out ☒ 18 - Vasectomy Referral Fee

Pregnancy Related Services
☐ 21 - Post Pregnancy Exam
☐ 31 - Serum Pregnancy Test ☐ 33 - Positive Pregnancy Test
☐ 32 - Negative Pregnancy Test ☐ 35 - Infertility Screening

13A. CONT. MEDICAL SERVICES (Check all Applicable)

STD Related Services
☐ 11 - Vaginitis/Urethritis/Eval/Dx ☐ 16 - Herpes Test
☐ 12 - Vaginitis/Urethritis/Eval/Rx ☐ 28 - Gonorrhea Test
☐ 29 - Chlamydia Test ☐ 30 - Wet Mount
☐ 13 - Chlamydia Treatment ☐ 43 - HIV Test Standard
☐ 14 - Chlamydia Presumptive Rx ☐ 44 - HIV Test Rapid
☐ 15 - Wart Treatment ☐ 47 - VDRL/RPR
☐ 50 - HPV Test

14A. COUNSELING EDUCATION PROVIDED (Check all Applicable)
☐ 01 - Contraceptive ☐ 09 - STD/HIV Prevention ☐ 18 - Relationship Safety
☐ 02 - Fertility Aware Mthd ☐ 10 - HIV Pre & Post
☐ 03 - Sterilization ☐ 16 - Abnormal Pap ☐ 12 - Nutrition
☐ 04 - Infertility ☐ 19 - BSE ☐ 05 - Tobacco
☐ 08 - Preconception ☐ 20 - TSE ☐ 06 - Substance Abuse
☐ 13 - Abstinence ☐ 15 - Crisis
☐ 07 - Pregnancy Options ☐ 17 - Encourage Parental/Family Involvement

19. PREGNANCY INTENTION SCREENING
☐ 1 - Yes, Near Future ☐ 3 - Unsure
☐ 2 - No, Maybe Later ☐ 4 - Never

13B.14B. PROVIDER OF MEDICAL SERVICES/COUNSELING/EDUCATION SERVICES (Mark all that Apply)
☐ 1 - Physicians
☐ 2 - Physician Assistants, Nurse Practitioners, Certified Nurse Midwives
☐ 3 - RNs, LPNs
☐ 4 - Other service providers, health educators, social workers, clinic aides and lab technicians.

15A. PRIMARY CONTRACEPTIVE METHOD
(Complete before and after blocks)

HIGHLY EFFECTIVE
14 - Male Sterilization
01 - Female Sterilization
11 - Hormone Implant
15 - IUS
03 - IUD
22 – LAM

MODERATELY EFFECTIVE
16 - Hormonal Injection
02 - Oral Contraceptives
17 - Hormonal Patch
18 - Vaginal Ring
04 - Diaphragm/Cap

LESS EFFECTIVE
06 - Male Condom
19 - Female Condom
21 - Contraceptive Sponge
20 - Withdrawal
08 - NFP/FAM
07 - Spermicide

OTHER
09 - Other Method
13 - Abstinence
10 - None

BEFORE VISIT AFTER VISIT

15B. IF NONE AT THE END OF THIS VISIT, GIVE REASON.
Pregnant ☐ 1 - Planned ☐ 8 - Unplanned ☐ 3 - Seeking Pregnancy
☐ 6 - Not Sexually Active ☐ 7 - Other

16. REFERRAL INFORMATION (Check all Applicable)
☐ 02 - High Risk Pregnancy ☐ 05 - Sterilization ☐ 10 - Social Sevices
☐ 15 - Adoption ☐ 06 - Infertility ☐ 09 - Nutrition
☐ 03 - Abortion ☐ 07 - NFP/FAM ☐ 13 - Substance Abuse
☐ 01 - Prenatal ☐ 04 - STD ☐ 14 - Abuse/Violence
☐ 16 - Breast Evaluation ☐ 17 - Colposcopy ☐ 11 - None
☐ 12 - Mammography or U.S. ☐ 08 - Other Medical

17. MEDICAID BILLING (Complete top section for CCare)

Supplies Billed	Qty.	Unit Price	Supplies Billed	Qty.	Unit Price
01-Orals			07-Condoms, Male		
16-EC			08-Condoms, Fem.		
14-Patch			12-Cervical Cap		
15-Mirena IUD			17-Ring		
03-Copper IUD			18-Sponge		
04-Depo Provera			19-Subdermal Implants		
05-Diaphragm			20-Cycle Beads		
06-Spermicide			21-Skyla IUS		

17A. THIRD PARTY RESOURCE CODES
(Complete if client has other insurance coverage.)
1 - Explanation Code
2 - Other Insurance Paid

SAMPLE OVP STERILIZATION PROCEDURE

OREGON CLINIC VISIT RECORD

A. LAST NAME Smith B. FIRST NAME Bob C. M.I.

D. SOC. SEC. NO. E. CCare NO.

Items A-E only required for CCare Clients

1. SERVICE SITE NUMBER 1 2 3 4 5 6 7
2. CLIENT NUMBER 8 9 1 0 1 1 1 2 1
3. DATE OF VISIT MO. 0 3 DAY 0 5 YR. 2 0 1 5
4. DATE OF BIRTH MO. 0 6 DAY 1 5 YR. 1 9 6 0
5. GENDER ☐ 1 - Female ☐ 2 - Male
6. ETHNICITY ☐ 6 - Hispanic or Latino ☐ 9 - Not Hispanic or Latino

6a. RACE (Mark All That Apply)
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☐ 08 - CCare* ☐ 06 - Partial Fee ☒ 11 - OVP
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9A. DIAGNOSIS CODE (Complete if Question 9 is 8) V25.

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(Complete if Question 9 is 8 or 10). ☐ 1- No ☐ 2- Yes (Complete 17A.)

9C. SPECIAL CONFIDENTIALITY NEEDS ☐ 1-Yes

18. CLIENT INSURANCE STATUS (check one)
(Principal Health Insurance covering primary care)
☐ 1 - Public Health Insurance ☐ 3 - Uninsured
☐ 2 - Private Health Insurance ☐ 4 - Unknown

10. INCOME AND FAMILY SIZE
a. What is your monthly family income? AMOUNT
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☐ 1 - Onsite ☐ 2 - Referral

12. PURPOSE OF VISIT (Check One)
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☐ 2 - Return Annual Exam ☐ 6 - Supply Only-Mailed (CCare Only)
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☐ 06 - Breast Exam ☐ 34 - Immunization
☐ 07 - Abdominal Exam ☐ 42 - Male Genitalia Exam
☐ 08 - Extremities ☐ 49 - Colo-Rectal Cancer Screening
☐ 09 - Bimanual/Speculum Pelvic Exam ☐ 36 - Other Lab or Exam
☐ 23 - Hgb / Hct ☐ 37 - No Lab or Exam

Contraceptive Related Services
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☐ 19 - IUD/IUS Insert ☐ 48 - EC-Immediate Need
☒ 20 - Sterilization Procedure ☐ 46 - EC-Future Need
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☐ 39 - Hormone Implant Out ☐ 18 - Vasectomy Referral Fee

Pregnancy Related Services
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☐ 31 - Serum Pregnancy Test ☐ 33 - Positive Pregnancy Test
☐ 32 - Negative Pregnancy Test ☐ 35 - Infertility Screening

13A. CONT. MEDICAL SERVICES (Check all Applicable)

STD Related Services
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☐ 29 - Chlamydia Test ☐ 30 - Wet Mount
☐ 13 - Chlamydia Treatment ☐ 43 - HIV Test Standard
☐ 14 - Chlamydia Presumptive Rx ☐ 44 - HIV Test Rapid
☐ 15 - Wart Treatment ☐ 47 - VDRL/RPR
☐ 50 - HPV Test

14A. COUNSELING EDUCATION PROVIDED (Check all Applicable)
☐ 01 - Contraceptive ☐ 09 - STD/HIV Prevention ☐ 18 - Relationship Safety
☐ 02 - Fertility Aware Mthd ☐ 10 - HIV Pre & Post
☐ 03 - Sterilization ☐ 16 - Abnormal Pap ☐ 12 - Nutrition
☐ 04 - Infertility ☐ 19 - BSE ☐ 05 - Tobacco
☐ 08 - Preconception ☐ 20 - TSE ☐ 06 - Substance Abuse
☐ 13 - Abstinence ☐ 15 - Crisis
☐ 07 - Pregnancy Options ☐ 17 - Encourage Parental/Family Involvement

19. PREGNANCY INTENTION SCREENING
☐ 1 - Yes, Near Future ☐ 3 - Unsure
☐ 2 - No, Maybe Later ☐ 4 - Never

13B.14B. PROVIDER OF MEDICAL SERVICES/COUNSELING/EDUCATION SERVICES (Mark all that Apply)
☐ 1 - Physicians
☐ 2 - Physician Assistants, Nurse Practitioners, Certified Nurse Midwives
☐ 3 - RNs, LPNs
☐ 4 - Other service providers, health educators, social workers, clinic aides and lab technicians.

15A. PRIMARY CONTRACEPTIVE METHOD
(Complete before and after blocks)

HIGHLY EFFECTIVE	MODERATELY EFFECTIVE	LESS EFFECTIVE
14 - Male Sterilization	16 - Hormonal Injection	06 - Male Condom
01 - Female Sterilization	02 - Oral Contraceptives	19 - Female Condom
11 - Hormone Implant	17 - Hormonal Patch	21 - Contraceptive Sponge
15 - IUS	18 - Vaginal Ring	20 - Withdrawal
03 - IUD	04 - Diaphragm/Cap	08 - NFP/FAM
22 - LAM		07 - Spermicide
		OTHER
		09 - Other Method
		13 - Abstinence
		10 - None

BEFORE VISIT ☐☐ AFTER VISIT ☐☐

15B. IF NONE AT THE END OF THIS VISIT, GIVE REASON.
Pregnant ☐ 1 - Planned ☐ 8 - Unplanned ☐ 3 - Seeking Pregnancy
☐ 6 - Not Sexually Active ☐ 7 - Other

16. REFERRAL INFORMATION (Check all Applicable)
☐ 02 - High Risk Pregnancy ☐ 05 - Sterilization ☐ 10 - Social Sevices
☐ 15 - Adoption ☐ 06 - Infertility ☐ 09 - Nutrition
☐ 03 - Abortion ☐ 07 - NFP/FAM ☐ 13 - Substance Abuse
☐ 01 - Prenatal ☐ 04 - STD ☐ 14 - Abuse/Violence
☐ 16 - Breast Evaluation ☐ 17 - Colposcopy ☐ 11 - None
☐ 12 - Mammography or U.S. ☐ 08 - Other Medical

17. MEDICAID BILLING (Complete top section for CCare)

Supplies Billed	Qty.	Unit Price	Supplies Billed	Qty.	Unit Price
01-Orals			07-Condoms, Male		
16-EC			08-Condoms, Fem.		
14-Patch			12-Cervical Cap		
15-Mirena IUD			17-Ring		
03-Copper IUD			18-Sponge		
04-Depo Provera			19-Subdermal Implants		
05-Diaphragm			20-Cycle Beads		
06-Spermicide			21-Skyla IUS		

17A. THIRD PARTY RESOURCE CODES
(Complete if client has other insurance coverage.)
1 - Explanation Code
2 - Other Insurance Paid