



Women's Care Form

Please fax completed forms and medical record documentation to 833-667-1532 or send to our secure email MIHEDIS@mhplan.com and save a copy in the patient's medical record.

Patient Name: _____ DOB: _____

ID#: _____

Cervical Cancer Screening	Breast Cancer Screening
Date of Pap Screening: ___/___/___ Result: _____ Date of HPV Screening: ___/___/___ Result: _____	Date of Screening: ___/___/___ Result: _____ _____ _____
Chlamydia Screening	
Date of Screening: ___/___/___ Result (choose one): <input type="radio"/> Positive <input type="radio"/> Negative	

Provider Signature: _____ Date: ___/___/___

Provider Name and Credentials (Print): _____

If an office or clinical support staff member fills out the form, it must be routed back to the provider for follow-up and signoff.



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