Aetna Better Health®of Pennsylvania
Aetna Better Health® Kids
2000 Market Street, Suite 850
Philadelphia, PA 19103
Quality Management Department
Fax- 860-754-0337

Location Name _____
Location Type _____
Location Address _____
Location Phone Number_____
Date of Service/Event _____

Aetna Better Health/ Aetna Better Health Kids Member ID#:_____

Member Name: _____ Date of Birth: _____

Confidential Member Record of Care Form

Prevention		Screenings	
Adult BMI Value	BMI Value Result:_____ Height:_____ Weight:_____	**Blood Pressure**	Blood Pressure Reading _____/_____
BMI Percentile- use for ages 20 & under	BMI Percentile: _____ Height:_____ Weight:_____	**HbA1C Test** **Glucose Test**	HbA1c Result _____ Glucose Test Result_____
Well Child Visit	Health History ☐ Physical Development History ☐ Mental Development History ☐ Physical Exam ☐ Anticipatory Guidance ☐	**Lead Testing**- Capillary Draw ☐ Venous Draw ☐	Lead Test Result _____
Wellness Counseling	Counseling for Nutrition ☐ Counseling for Physical Activity ☐ Obesity/Weight Loss Counseling☐	**Urine Micro-albumin Test**	Micro-albumin Test Result _____
Meningococcal Vaccine*	Date administered: / /	**Date:** ___/___/____ **Service Provider Signature:** _____ **Service Provider Credentials:** _____	
Td Vaccine*	Date administered: / /		
Tdap Vaccine*	Date administered: / /		
HPV Vaccine*	Date administered: / / *Please attach appropriate identifying information for vaccines administered.		

Women's Health Services				
		Prenatal Testing		
Mammogram ☐	Result _____	Torch Antibody ___	Obstetric Panel ___	ABO/RH Typing _____
HPV Testing ☐	Result_____	OB History _____	Prenatal Risk Assessment ___	Pelvic Exam _____
		EDD _____	LMP _____	Ultrasound _____
Chlamydia Testing ☐	Result_____	**Service Provider Signature:** _____ **Service Provider Credentials:** _____ **Date:** / /		
Cervical Cytology ☐	Result_____			

Diabetic Retinal Exam		Dental Services	
Retinal Exam ☐ Dilated Eye Exam ☐	Result- Positive ☐ Negative ☐	Exam ☐ Cleaning ☐ Tooth Sealants ☐	Fluoride Treatment ☐ X-ray ☐ Fillings ☐
Service Provider Signature: _____ **Service Provider Credentials:** _____ **Date:** / /		**Service Provider Signature:** _____ **Service Provider Credentials:** _____ **Date:** / /	

Note: This record of care form will be forwarded to the member's primary care physician for addition to the health record, aiding continuity of care.