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): ○ Positive ○ 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.