**QUICK REFERENCE INFORMATION: Preventive Services**

This educational tool provides information on Medicare preventive services. Information provided includes Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes; International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes; coverage requirements; frequency requirements; and beneficiary liability for each Medicare preventive service.

### Service

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<tr>
<td>Initial Preventive Physical Examination (IPPE)</td>
<td>G0402 – IPPE, G0403 – EKG for IPPE, G0404 – EKG tracing for IPPE, G0405 – EKG interpret &amp; report for IPPE</td>
<td>No specific diagnosis code</td>
<td>All Medicare beneficiaries whose first Part B coverage began on or after 01/01/05</td>
<td>Once in a lifetime (Must furnish no later than 12 months after the effective date of the first Medicare Part B coverage)</td>
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<td>Also known as the “Welcome to Medicare Preventive Visit”</td>
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<td>Contact the local Medicare Contractor for guidance</td>
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<td>G0403, G0404, and G0405: Copayment/coinsurance applies, Deductible applies</td>
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<td>Annual Wellness Visit (AWV)</td>
<td>G0438 – Initial visit, G0439 – Subsequent visit</td>
<td>No specific diagnosis code</td>
<td>All Medicare beneficiaries who are no longer within 12 months after the effective date of their first Medicare Part B coverage period and who have not received an IPPE or AWV within the past 12 months</td>
<td>Once in a lifetime for G0438 (Annually for G0439)</td>
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<td>Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)</td>
<td>G0389 – Ultrasound exam AAA screening</td>
<td>No specific diagnosis code</td>
<td>Medicare beneficiaries with certain risk factors for AAA</td>
<td>Once in a lifetime</td>
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<td>Cardiovascular Screening Blood Tests</td>
<td>80061 – Lipid panel, 82465 – Cholesterol, 83718 – Lipoprotein, 84478 – Triglycerides</td>
<td>Report one or more of the following codes: V81.0, V81.1, V81.2</td>
<td>All Medicare beneficiaries without apparent signs or symptoms of cardiovascular disease</td>
<td>Every 5 years</td>
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<td>Diabetes Screening Tests</td>
<td>82947 – Glucose; quantitative, blood (except reagent strip), 82950 – Glucose; post-glucose dose (includes glucose), 82951 – Glucose; tolerance test (GTT), 3 specimens (includes glucose)</td>
<td>V77.1</td>
<td>Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes</td>
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<td>Diabetes Self-Management Training (DSMT)</td>
<td>G0108 – DSMT, individual, per 30 minutes, G0109 – DSMT, group (2 or more), per 30 minutes</td>
<td>No specific diagnosis code</td>
<td>Medicare beneficiaries diagnosed with diabetes</td>
<td>Up to 10 hours of initial training within a continuous 12-month period. Subsequent years: Up to 2 hours of follow-up training each year after the initial year</td>
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| Medical Nutrition Therapy (MNT) | 97802 – MNT; initial assessment, individual, each 15 minutes  
97803 – MNT; re-assessment, individual, each 15 minutes  
97804 – MNT; group (2 or more), each 30 minutes  
G0270 – MNT reassessment and subsequent intervention(s) for change in diagnosis, individual, each 15 minutes  
G0271 – MNT reassessment and subsequent intervention(s) for change in diagnosis, group (2 or more), each 30 minutes | No specific diagnosis code  
Contact the local Medicare Contractor for guidance | Certain Medicare beneficiaries diagnosed with diabetes, renal disease, or who have received a kidney transplant within the last 3 years  
A registered dietitian or nutrition professional must provide the services | • First year: 3 hours of one-on-one counseling  
• Subsequent years: 2 hours | • Copayment/coinsurance waived  
• Deductible waived |
| Screening Pap Tests             | G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148 – Screening cytology, cervical or vaginal  
P3000 – Screening Pap smear by technician under physician supervision  
P3001 – Screening Pap smear requiring interpretation by physician  
Q0091 – Screening Pap smear; obtaining, preparing and conveyance to lab | Report one of the following codes:  
Low Risk – V72.31, V76.2, V76.47, V76.49  
High Risk – V15.89 | All female Medicare beneficiaries | • Annually if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past 3 years  
• Every 24 months for all other women | • Copayment/coinsurance waived  
• Deductible waived |
| Screening Pelvic Examinations   | G0101 – Cervical or vaginal cancer screening; pelvic and clinical breast examination | Report one of the following codes:  
Low Risk – V72.31, V76.2, V76.47, V76.49  
High Risk – V15.89 | All female Medicare beneficiaries | • Annually if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past 3 years  
• Every 24 months for all other women | • Copayment/coinsurance waived  
• Deductible waived |
| Screening Mammography           | 77052 – Computer-aided detection; screening mammography  
77057 – Screening mammography, bilateral  
G0202 – Screening mammography, digital | Report one of the following codes:  
V76.11 or V76.12 | All female Medicare beneficiaries aged 35 and older | • Aged 35 through 39: One baseline  
• Aged 40 and older: Annually | • Copayment/coinsurance waived  
• Deductible waived |
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<td>Bone Mass Measurements</td>
<td>76977 – Ultrasound bone density measurement and interpretation; peripheral site(s), any method 77078 – Computed tomography, bone mineral density study, 1 or more sites; axial skeleton 77079 – Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel) 77080 – Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton 77081 – DXA, bone density study, 1 or more sites; appendicular skeleton 77083 – Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), 1 or more sites G0130 – Single energy X-ray study</td>
<td>No specific diagnosis code Contact the local Medicare Contractor for guidance</td>
<td>Certain Medicare beneficiaries that fall into at least one of the following categories:  • Women determined by their physician or qualified non-physician practitioner to be estrogen deficient and at clinical risk for osteoporosis;  • Individuals with vertebral abnormalities;  • Individuals receiving (or expecting to receive) glucocorticoid therapy for more than 3 months;  • Individuals with primary hyperparathyroidism; or  • Individuals being monitored to assess response to FDA-approved osteoporosis drug therapy</td>
<td>Every 24 months More frequently if medically necessary</td>
<td>• Copayment/coinsurance waived  • Deductible waived</td>
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<td>Colorectal Cancer Screening</td>
<td>G0104 – Flexible Sigmoidoscopy G0105 – Colonoscopy (high risk) G0106 – Barium Enema (alternative to G0104) G0120 – Barium Enema (alternative to G0105) G0121 – Colonoscopy (not high risk) G0328 – Fecal Occult Blood Test (FOBT), immunoassay, 1-3 simultaneous feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection) 82270 – FOBT (blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening)</td>
<td>No specific diagnosis code Contact the local Medicare Contractor for guidance</td>
<td>All Medicare beneficiaries aged 50 and older who are:  • At normal risk of developing colorectal cancer; or  • At high risk of developing colorectal cancer High risk for developing colorectal cancer is defined in 42 CFR 410.37(a)(3) Refer to <a href="http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-37.pdf">http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-37.pdf</a> on the Internet</td>
<td>FOBT every year  • Flexible Sigmoidoscopy once every 4 years, or 120 months after a previous Screening Colonoscopy for people not at high risk  • Screening Colonoscopy every 10 years (every 24 months for high risk), or 48 months after a previous Flexible Sigmoidoscopy  • Barium Enema (as an alternative to a covered Flexible Sigmoidoscopy) every 48 months, and every 24 months for high risk</td>
<td>G0104, G0105, G0121, G0328, and 82270:  • Copayment/coinsurance waived  • Deductible waived G0106 and G0120:  • Copayment/coinsurance applies  • Deductible waived No deductible for all surgical procedures (CPT code range of 10000 to 69999) furnished on the same date and in the same encounter as a Colonoscopy, Flexible Sigmoidoscopy, or Barium Enema that were initiated as colorectal cancer screening services Modifier -PT should be appended to at least one CPT code in the surgical range of 10000 to 69999 on a claim for services furnished in this scenario</td>
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| Prostate Cancer Screening | G0102 – Digital Rectal Exam (DRE) G0103 – Prostate Specific Antigen Test (PSA) | V76.44 | All male Medicare beneficiaries aged 50 and older (coverage begins the day after 50th birthday) | Annually for covered beneficiaries | G0102:  
• Copayment/coinsurance applies  
• Deductible applies  
G0103:  
• Copayment/coinsurance waived  
• Deductible waived |
| Glaucoma Screening | G0117 – By an optometrist or ophthalmologist  
G0118 – Under the direct supervision of an optometrist or ophthalmologist | V80.1 | Medicare beneficiaries with diabetes mellitus, family history of glaucoma, African-Americans aged 50 and older, or Hispanic-Americans aged 65 and older | Annually for covered beneficiaries |  
• Copayment/coinsurance applies  
• Deductible applies |
| Seasonal Influenza Virus Vaccine and Administration | 90654, 90655, 90656, 90657, 90660, 90662, Q2034 (effective for dates of service on or after 07/01/12, and claims processed on or after 10/01/12), Q2035, Q2036, Q2037, Q2038, Q2039 – Influenza Virus Vaccine  
G0008 – Administration | Report one of the following codes:  
V04.81 – Influenza  
V06.6 – Pneumococcus and Influenza | All Medicare beneficiaries | Once per influenza season  
Medicare may provide additional flu shots if medically necessary |  
• Copayment/coinsurance waived  
• Deductible waived |
| Pneumococcal Vaccine and Administration | 90669, 90670 – Pneumococcal Conjugate Vaccine  
90732 – Pneumococcal Polysaccharide Vaccine  
G0009 – Administration | Report one of the following codes:  
V03.82 – Pneumococcus  
V06.6 – Pneumococcus and Influenza | All Medicare beneficiaries | Once in a lifetime  
Medicare may provide additional vaccinations based on risk and provided that at least 5 years have passed since receipt of a previous dose |  
• Copayment/coinsurance waived  
• Deductible waived |
| Hepatitis B (HBV) Vaccine and Administration | 90740 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule)  
90743 – Hepatitis B vaccine, adolescent dosage (2 dose schedule)  
90744 – Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule)  
90746 – Hepatitis B vaccine, adult dosage  
90747 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule)  
G0010 – Administration | V05.3 | Certain Medicare beneficiaries at intermediate or high risk for contracting hepatitis B  
Medicare beneficiaries that are currently positive for antibodies for hepatitis B are not eligible for this benefit | Scheduled dosages required |  
• Copayment/coinsurance waived  
• Deductible waived |
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| **Counseling to Prevent Tobacco Use for Asymptomatic Beneficiaries** | G0436 – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes | Report one of the following codes: 305.1 or V15.82 | Outpatient and hospitalized beneficiaries who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease; who are competent and alert at the time that counseling is provided; and whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner | Two cessation attempts per year; each attempt includes a maximum of four intermediate or intensive sessions, up to eight sessions in a 12-month period | • Copayment/coinsurance waived  
• Deductible waived |
|            | G0437 – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes | | | | |
| **Human Immunodeficiency Virus (HIV) Screening** | G0432 – Infectious agent antibody detection by enzyme immunoassay (EIA) technique | Report one of the following codes: V73.89 – Primary  
V22.0, V22.1, V69.8, or V23.9 – Secondary, as appropriate | Beneficiaries who are at increased risk for HIV infection or pregnant  
Increased risk for HIV infection is defined in Publication 100-03, Sections 190.14 (diagnostic) and 210.7 (screening)  
Three times per pregnancy for beneficiaries who are pregnant:  
• First, when a woman is diagnosed with pregnancy;  
• Second, during the third trimester; and  
• Third, at labor, if ordered by the woman’s clinician | • Copayment/coinsurance waived  
• Deductible waived |
|            | G0433 – Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique | | | | |
|            | G0435 – Infectious agent antibody detection by rapid antibody test | | | | |
| **Intensive Behavioral Therapy (IBT) for Cardiovascular Disease** | G0446 – Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, bi-annual, 15 minutes | No specific diagnosis code | Men aged 45 through 79 and women aged 55 through 79: Encouraging aspirin use for the primary prevention of cardiovascular disease when the benefits outweigh the risks  
• Adults aged 18 and older: Screening for high blood pressure  
• Adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular- and diet-related chronic disease: Intensive behavioral counseling to promote a healthy diet  
Must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting | Annually for covered beneficiaries | • Copayment/coinsurance waived  
• Deductible waived |
| **Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse** | G0442 – Annual alcohol misuse screening, 15 minutes | No specific diagnosis code | All Medicare beneficiaries are eligible for alcohol screening  
Medicare beneficiaries who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence, are eligible for counseling if they are competent and alert at the time that counseling is provided and counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting | • Annually for G0442  
• Four times per year for G0443 | • Copayment/coinsurance waived  
• Deductible waived |
<p>|            | G0443 – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes | Contact the local Medicare Contractor for guidance | | | |</p>
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| **Screening for Depression**  
*This is a new benefit beginning for dates of service on or after 10/14/11* | G0444 – Annual depression screening, 15 minutes | No specific diagnosis code | All Medicare beneficiaries  
Must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up | Annually | • Copayment/coinsurance waived  
• Deductible waived |
| **Sexually Transmitted Infections (STIs) Screening and High Intensity Behavioral Counseling (HIBC) to Prevent STIs**  
*This is a new benefit beginning for dates of service on or after 11/08/11* | G0445 – High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes | For screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant report V74.5 and V69.8  
For screening for syphilis in men at increased risk report V74.5 and V69.8  
For screening for chlamydia and gonorrhea in pregnant women at increased risk for STIs report:  
• V74.5 and V69.8, and  
• V22.0, V22.1, or V23.9  
For screening for syphilis in pregnant women report V74.5 and V22.0, V22.1, or V23.9  
For screening for syphilis in pregnant women at increased risk for STIs report:  
• V74.5 and V69.8, and  
• V22.0, V22.1, or V23.9   
For screening for hepatitis B in pregnant women report V73.89 and V22.0, V22.1, or V23.9  
For screening for hepatitis B in pregnant women at increased risk for STIs report:  
• V73.89 and V69.8, and  
• V22.0, V22.1, or V23.9   
Sexually active adolescents and adults at increased risk for STIs: HIBC consisting of individual, 20 to 30 minute, face-to-face counseling sessions, if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting  
Increased risk for STIs is defined in Publication 100-03, Section 210.10  
• One annual occurrence of screening for syphilis in men at increased risk  
• Up to two occurrences per pregnancy of screening for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening  
• One occurrence per pregnancy of screening for syphilis in pregnant women who are at increased risk for STIs  
• Up to two additional occurrences per pregnancy if at continued increased risk for STIs  
• One occurrence per pregnancy of screening for hepatitis B in pregnant women; one additional occurrence per pregnancy if at continued increased risk for STIs  
• Up to two HIBC counseling sessions annually | • Copayment/coinsurance waived  
• Deductible waived |
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| Intensive Behavioral Therapy (IBT) for Obesity | G0447 – Face-to-face behavioral counseling for obesity, 15 minutes | Report one of the following codes: V85.30 – V85.39, V85.41 – V85.45 | Medicare beneficiaries with obesity (BMI ≥ 30 kg/m²) who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting | • One visit every week for the first month;  
• One visit every other week for months 2 – 6; and  
• One visit every month for months 7 – 12  
At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed  
To be eligible for additional face-to-face visits occurring once a month for an additional 6 months, beneficiaries must have lost at least 3kg  
For beneficiaries who do not achieve a weight loss of at least 3kg during the first 6 months, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period | • Copayment/coinsurance waived  
• Deductible waived |

**Frequently Asked Questions**

**Why is CMS adding new preventive services as Medicare benefits?**
Under Section 4105 of the Affordable Care Act, CMS may add coverage of “additional preventive services” through the National Coverage Determination (NCD) process if the service meets all of the following criteria. They must be: 1) reasonable and necessary for the prevention or early detection of illness or disability, 2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and 3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare Program. For more information on USPSTF recommendations, visit [http://www.uspreventiveservicestaskforce.org/recommendations.htm](http://www.uspreventiveservicestaskforce.org/recommendations.htm) on the Internet. Watch for announcements of additional new preventive benefits and educational materials at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html) on the CMS website, or refer to [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNProducts_listserv.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNProducts_listserv.pdf) to sign up to receive news of new Medicare Learning Network® (MLN) products by e-mail. For the latest information on Medicare preventive services, visit [http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/News_and_Announcements.html](http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/News_and_Announcements.html) on the CMS website.

**Some services must be performed in a primary care setting. What is that?**
A primary care setting is one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. We do not consider Ambulatory Surgical Centers (ASCs), emergency departments, hospices, independent diagnostic testing facilities, inpatient hospital settings, Inpatient Rehabilitation Facilities (IRFs), and Skilled Nursing Facilities (SNFs) to be primary care settings under this definition.

**How do I determine the last date a beneficiary received a preventive service, so that I know the beneficiary is eligible to receive the next service and the service will not be denied due to frequency edits?**
Your options for accessing eligibility information depend on the Medicare Administrative Contractor (MAC) jurisdiction in which your practice or facility is located. For example, MACs who have Internet portals provide the information through the eligibility screens of the portals. You may also be able to access the information through the HIPAA Eligibility Transaction System (HETS), as well as HETS User Interface, through the provider call center Interactive Voice Responses (IVRs). CMS suggests that providers check with their MAC to see what options are available to check eligibility.

**My patients do not follow up on routine preventive care. How can I help them remember when they are due for their next preventive service?**
[Medicare.gov](https://www.medicare.gov) provides a “Preventive Screening Checklist” that you can give to your patients. They can use the checklist to track their preventive services. For the checklist, visit [http://www.medicare.gov/navigation/manage-your-health/preventive-services/preventive-service-checklist.aspx](http://www.medicare.gov/navigation/manage-your-health/preventive-services/preventive-service-checklist.aspx) on the Internet.
# Resources

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<td>Medicare Preventive Services General Information</td>
<td><a href="http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo">http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo</a></td>
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