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QUICK REFERENCE INFORMATION:
Preventive Services

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This educational tool provides the following information on Medicare preventive services: 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.

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Medicare Preventive Services

Service	HCPCS/CPT Codes	ICD-9-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Annual Wellness Visit (AWV)	G0438 – Initial visit G0439 – Subsequent visit	No specific diagnosis code Contact the local Medicare Administrative Contractor (MAC) for guidance	All Medicare beneficiaries who are not within 12 months after the effective date of their first Medicare Part B coverage period and who have not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months	Once in a lifetime for G0438 (first AWV) **or** Annually for G0439 (subsequent AWV)	• Copayment/ coinsurance waived • Deductible waived
Bone Mass Measurements	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 (eg, hips, pelvis, spine) 77080 – Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine) 77081 – DXA, bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel) G0130 – Single energy X-ray study, 1 or more sites, appendicular skeleton	No specific diagnosis code Contact the local MAC for guidance	Certain Medicare beneficiaries who 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 getting (or expecting to get) glucocorticoid therapy for more than 3 months; • Individuals with primary hyperparathyroidism; or • Individuals being monitored to assess response to U.S. Food and Drug Administration (FDA)-approved osteoporosis drug therapy	Every 2 years **or** More frequently if medically necessary	• Copayment/ coinsurance waived • Deductible waived

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-9-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Cardiovascular Disease Screening Blood Tests	80061 – Lipid panel, this panel must include the following: 82465 – Cholesterol, serum, total 83718 – Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) 84478 – Triglycerides	Report one or more of the following codes: V81.0, V81.1, V81.2	All Medicare beneficiaries without apparent signs or symptoms of cardiovascular disease	Every 5 years	• Copayment/ coinsurance waived • Deductible waived
Colorectal Cancer Screening	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 82270 – Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)	No specific diagnosis code Contact the local MAC for guidance	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). For more information, refer to http://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol2/pdf/CFR-2013-title42-vol2-sec410-37.pdf on the United States Government Printing Office (GPO) website. **NOTE:** For coverage of screening colonoscopies, there is no age limitation.	**Normal Risk:** • Screening fecal occult blood test (FOBT) every year; • Screening flexible sigmoidoscopy once every 4 years (unless a screening colonoscopy has been performed and then Medicare may cover a screening flexible sigmoidoscopy only after at least 119 months); • Screening colonoscopy every 10 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after 47 months); and • Screening barium enema (as an alternative to covered screening flexible sigmoidoscopy) **High Risk:** • Screening FOBT every year; • Screening flexible sigmoidoscopy once every 4 years; • Screening colonoscopy every 2 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after at least 47 months); and • Screening barium enema (as an alternative to covered screening colonoscopy)	**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.

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-9-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
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 G0437 – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes	Report one of the following codes: 305.1 or V15.82	Outpatient and hospitalized beneficiaries: • Who use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease; • Who are competent and alert at the time of counseling; and • Who get counseling furnished by a qualified physician or other Medicare-recognized practitioner	Two cessation counseling attempts (up to 8 counseling sessions) per year	• Copayment/ coinsurance waived • Deductible waived
Diabetes Screening Tests	82947 – Glucose; quantitative, blood (except reagent strip) 82950 – Glucose; postglucose dose (includes glucose) 82951 – Glucose; tolerance test (GTT), 3 specimens (includes glucose)	V77.1	Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes **but** Beneficiaries previously diagnosed with diabetes are **not** eligible for this benefit	Two screening tests per year for beneficiaries diagnosed with pre-diabetes **or** One screening per year if previously tested, but not diagnosed with pre-diabetes, or if never tested	• Copayment/ coinsurance waived • Deductible waived
Diabetes Self-Management Training (DSMT)	G0108 – DSMT, individual, per 30 minutes G0109 – DSMT, group (2 or more), per 30 minutes	No specific diagnosis code Contact the local MAC for guidance	Certain Medicare beneficiaries diagnosed with diabetes **where** A physician or qualified non-physician practitioner treating the beneficiary's diabetes orders DSMT	Up to 10 hours of initial training within a continuous 12-month period **or** Subsequent years: Up to 2 hours of follow-up training each year after the initial year	• Copayment/ coinsurance applies • Deductible applies
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

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-9-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Hepatitis B (HBV) Vaccine and Administration	90739 – Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use 90740 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use 90743 – Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use 90744 – Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use 90746 – Hepatitis B vaccine, adult dosage (3 dose schedule), for intramuscular use 90747 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use G0010 – Administration	V05.3	Certain Medicare beneficiaries at intermediate or high risk for contracting hepatitis B **but** Medicare beneficiaries who are currently positive for antibodies for hepatitis B are **not** eligible for this benefit	Scheduled dosages required	• Copayment/ coinsurance waived • Deductible waived
Human Immunodeficiency Virus (HIV) Screening	G0432 – Infectious agent antibody detection by enzyme immunoassay (EIA) technique G0433 – Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique G0435 – Infectious agent antibody detection by rapid antibody test	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). For more information, refer to http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part3.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf on the Centers for Medicare & Medicaid Services (CMS) website.	Annually for beneficiaries at increased risk, including anyone who asks for the test For beneficiaries who are pregnant, 3 times per pregnancy: • 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

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-9-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Influenza Virus Vaccine and Administration	90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673*, 90685, 90686, 90687, 90688, Q2033*, Q2034, Q2035, Q2036, Q2037, Q2038, Q2039 – Influenza Virus Vaccine G0008 – Administration * Medicare will recognize HCPCS code Q2033 for dates of service on or after July 1, 2013, processed on or after October 7, 2013. CPT code 90673 will replace HCPCS code Q2033 on January 1, 2014.	Report one of the following codes: V04.81 – Influenza V06.6 – Pneumococcus and Influenza	All Medicare beneficiaries	Once per influenza season **and** Medicare may provide additional flu shots if medically necessary	• Copayment/ coinsurance waived • Deductible waived
Initial Preventive Physical Examination (IPPE) Also known as the "Welcome to Medicare Preventive Visit"	G0402 – IPPE G0403 – EKG for IPPE G0404 – EKG tracing for IPPE G0405 – EKG interpret & report for IPPE	No specific diagnosis code Contact the local MAC for guidance	All new Medicare beneficiaries who are within the first 12 months of their first Medicare Part B coverage period **Important** – The screening EKG is an optional service that may be performed as a result of a referral from an IPPE.	Once in a lifetime **and** Must furnish no later than 12 months after the effective date of the first Medicare Part B coverage period	**G0402:** • Copayment/ coinsurance waived • Deductible waived **G0403, G0404, and G0405:** • Copayment/ coinsurance applies • Deductible applies
Intensive Behavioral Therapy (IBT) for Cardiovascular Disease Also referred to as a CVD risk reduction visit	G0446 – Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	No specific diagnosis code Contact the local MAC for guidance	All Medicare beneficiaries 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 and in a primary care setting	One CVD risk reduction visit annually	• Copayment/ coinsurance waived • Deductible waived

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-9-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
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 kilograms per meter squared) 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, if certain requirements are met 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
Medical Nutrition Therapy (MNT)	97802 – MNT; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes 97803 – MNT; re-assessment and intervention, individual, face-to-face with the patient each 15 minutes 97804 – MNT; group (2 or more individual(s)), 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 MAC for guidance	Certain Medicare beneficiaries who receive a referral from their treating physician and are diagnosed with diabetes, renal disease, or who have received a kidney transplant within the last 3 years **and** A registered dietitian or nutrition professional must provide the services	First year: 3 hours of one-on-one counseling **or** Subsequent years: 2 hours	• Copayment/ coinsurance waived • Deductible waived

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-9-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
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 **and** Medicare may provide revaccinations based on risk	• Copayment/ coinsurance waived • Deductible waived
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 their 50th birthday)	Annually for covered beneficiaries	**G0102:** • Copayment/ coinsurance applies • Deductible applies **G0103:** • Copayment/ coinsurance waived • Deductible waived
Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse	G0442 – Annual alcohol misuse screening, 15 minutes G0443 – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	No specific diagnosis code Contact the local MAC for guidance	All Medicare beneficiaries are eligible for alcohol screening. Medicare beneficiaries who screen positive (those 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 **or** For those who screen positive, 4 times per year for G0443	• Copayment/ coinsurance waived • Deductible waived
Screening for Depression	G0444 – Annual depression screening, 15 minutes	No specific diagnosis code Contact the local MAC for guidance	All Medicare beneficiaries **and** 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

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-9-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Screening Mammography	77052 – Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation; screening mammography (List separately in addition to code for primary procedure) 77057 – Screening mammography, bilateral (2-view film study of each breast) (Use 77055, 77056 in conjunction with 77051 for computer-aided detection applied to a diagnostic mammogram) G0202 – Screening mammography, digital, bilateral	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 **or** Aged 40 and older: Annually	• Copayment/ coinsurance waived • Deductible waived
Screening Pap Tests	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148 – Screening cytopathology, 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 **or** Every 2 years for women at normal risk	• 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 **or** Every 2 years for women at normal risk	• Copayment/ coinsurance waived • Deductible waived

Service	HCPCS/CPT Codes	ICD-9-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Sexually Transmitted Infections (STIs) Screening and High Intensity Behavioral Counseling (HIBC) to Prevent STIs	86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810 – Chlamydia 87590, 87591, 87850 – Neisseria gonorrhoeae 87800 – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique 86592 – Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) 86593 – Syphilis test, non-treponemal, quantitative 86780 – Treponema pallidum 87340, 87341 – Hepatitis B (hepatitis B surface antigen) G0445 – Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior	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. For more information, refer to http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf on the CMS website.	• One annual occurrence of screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant; • 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; 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; or • Up to two HIBC counseling sessions annually	• Copayment/ coinsurance waived • Deductible waived

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-9-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389 – Ultrasound exam for AAA screening	No specific diagnosis code Contact the local MAC for guidance	Medicare beneficiaries with certain risk factors for AAA **Important** – Eligible beneficiaries must receive a referral for an ultrasound screening for AAA from their physician, physician assistant, nurse practitioner, or clinical nurse specialist.	Once in a lifetime	• Copayment/ coinsurance waived • Deductible waived

Frequently Asked Questions

May CMS add new preventive services as Medicare benefits?

CMS may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process if the service meets all of the following criteria. The service 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 on the Internet. For the latest information on Medicare preventive services, visit http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/News_and_Announcements.html on the CMS website.

Stay Up-to-Date with the Latest Preventive Services News

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 on the CMS website, or refer to 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) educational materials on the electronic mailing list.

What is a primary care setting?

A primary care setting offers provisions of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, develops a sustained partnership with patients, and practices 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 got a preventive service, so that I know the beneficiary is eligible to get the next service and the service will not be denied due to frequency edits?

You have different options for accessing eligibility information depending on the Medicare Administrative Contractor (MAC) jurisdiction in which your practice or facility is located. You may 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 beneficiary 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 provides a "Preventive Services Checklist" you can give to your patients. They can use the checklist to track their preventive services. For the checklist, refer to http://www.medicare.gov/Pubs/pdf/11420.pdf on the Medicare website.

Resources

Resource	Website
Medicare Preventive Services General Information	http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo
MLN Guided Pathways (GPs) to Medicare Resources	The MLN Educational Web Guides MLN GPs help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information about preventive services, refer to the "Coverage of Preventive Services" section in the "MLN Guided Pathways: Basic Medicare Resources for Health Care Professionals, Suppliers, and Providers" booklet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf on the CMS website. For all other GPs resources, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html on the CMS website.
Preventive Services Educational Products	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/education_products_prevserv.pdf
Preventive Services MLN Web Page	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html or scan the Quick Response (QR) code on the right.
"Resources for Medicare Beneficiaries" Fact Sheet	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BenePubFS-ICN905183.pdf

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