DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION

(COMPLETE FOR INITIAL CLAIMS ONLY)

1. PATIENT'S LAST NAME	FIRST NAME M.I.	2. PROVIDER NO.	3. HICN
4. PROVIDER NAME	5. MEDICAL RECORD NO. *(Optional)*	6. ONSET DATE	7. SOC. DATE
8. TYPE ☐ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SN ☐ SW	9. PRIMARY DIAGNOSIS *(Pertinent Medical D.X.)*	10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.

12. PLAN OF TREATMENT FUNCTIONAL GOALS GOALS *(Short Term)* OUTCOME *(Long Term)*	PLAN
13. SIGNATURE *(professional establishing POC including prof. designation)*	14. FREQ/DURATION *(e.g., 3/Wk. x 4 Wk.)*
I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE ☐ N/A 15. PHYSICIAN SIGNATURE 16. DATE	17. CERTIFICATION FROM THROUGH N/A 18. ON FILE *(Print/type physician's name)* ☐
20. INITIAL ASSESSMENT *(History, medical complications, level of function at start of care. Reason for referral.)*	19. PRIOR HOSPITALIZATION FROM TO N/A

21. FUNCTIONAL LEVEL *(End of billing period)* PROGRESS REPORT ☐ CONTINUE SERVICES **OR** ☐ DC SERVICES

22. SERVICE DATES
FROM THROUGH