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

UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION

(Complete for Interim to Discharge Claims. Photocopy of CMS-700 or 701 is required.)

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	9. PRIMARY DIAGNOSIS *(Pertinent Medical D.X.)*	10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.
☐ PT ☐ OT ☐ SLP ☐ CR			
☐ RT ☐ PS ☐ SN ☐ SW	12. FREQ/DURATION *(e.g., 3/Wk. x 4 Wk.)*		

13. CURRENT PLAN UPDATE, FUNCTIONAL GOALS *(Specify changes to goals and plan.)*

GOALS *(Short Term)*	PLAN
OUTCOME *(Long Term)*	

I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. ☐ N/A ☐ DC	14. RECERTIFICATION FROM THROUGH N/A ☐

15. PHYSICIAN'S SIGNATURE	16. DATE	17. ON FILE *(Print/type physician's name)* ☐

18. REASON(S) FOR CONTINUING TREATMENT THIS BILLING PERIOD *(Clarify goals and necessity for continued skilled care.)*

19. SIGNATURE *(or name of professional, including prof. designation)*	20. DATE	21. ☐ CONTINUE SERVICES **OR** ☐ DC SERVICES

22. FUNCTIONAL LEVEL *(At end of billing period — Relate your documentation to functional outcomes and list problems still present.)*

22. SERVICE DATES FROM THROUGH

Form CMS-701(11-91)