

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. <i>(Optional)</i>		6. ONSET DATE	7. SOC. DATE
8. TYPE <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> CR <input type="checkbox"/> RT <input type="checkbox"/> PS <input type="checkbox"/> SN <input type="checkbox"/> SW	9. PRIMARY DIAGNOSIS <i>(Pertinent Medical D.X.)</i>		10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.
12. PLAN OF TREATMENT FUNCTIONAL GOALS GOALS <i>(Short Term)</i> OUTCOME <i>(Long Term)</i>			PLAN	
13. SIGNATURE <i>(professional establishing POC including prof. designation)</i>			14. FREQ/DURATION <i>(e.g., 3/Wk. x 4 Wk.)</i>	
I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE <input type="checkbox"/> N/A 15. PHYSICIAN SIGNATURE			17. CERTIFICATION FROM _____ THROUGH _____ N/A	
			18. ON FILE <i>(Print/type physician's name)</i> <input type="checkbox"/>	
20. INITIAL ASSESSMENT <i>(History, medical complications, level of function at start of care. Reason for referral.)</i>			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 _____

INSTRUCTIONS FOR COMPLETION OF FORM CMS-700

(Enter dates as 6 digits, month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial as shown on the health insurance Medicare card.
2. **Provider Number** - Enter the number issued by Medicare to the billing provider (*i.e.*, 00-7000).
3. **HICN** - Enter the patient's health insurance number as shown on the health insurance Medicare card, certification award, utilization notice, temporary eligibility notice, or as reported by SSO.
4. **Provider Name** - Enter the name of the Medicare billing provider.
5. **Medical Record No.** - (*optional*) Enter the patient's medical/clinical record number used by the billing provider.
6. **Onset Date** - Enter the date of onset for the patient's primary medical diagnosis, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact date is not known enter 01 for the day (*i.e.*, 120191). The date matches occurrence code 11 on the UB-92.
7. **SOC (start of care) Date** - Enter the date services began at the billing provider (the date of the first Medicare billable visit which **remains the same on subsequent claims** until discharge or denial corresponds to occurrence code 35 for PT, 44 for OT, 45 for SLP and 46 for CR on the UB-92).
8. **Type** - Check the type therapy billed; *i.e.*, physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), cardiac rehabilitation (CR), respiratory therapy (RT), psychological services (PS), skilled nursing services (SN), or social services (SW).
9. **Primary Diagnosis** - Enter the pertinent written medical diagnosis resulting in the therapy disorder and relating to 50% or more of effort in the plan of treatment.
10. **Treatment Diagnosis** - Enter the written treatment diagnosis for which services are rendered. For example, for PT the primary medical diagnosis might be Degeneration of Cervical Intervertebral Disc while the PT treatment DX might be Frozen R Shoulder or, for SLP, while CVA might be the primary medical DX, the treatment DX might be Aphasia. If the same as the primary DX enter SAME.
11. **Visits From Start of Care** - Enter the **cumulative total** visits (*sessions*) completed since services were started at the billing provider for the diagnosis treated, through the last visit on this bill. (*Corresponds to UB-92 value code 50 for PT, 51 for OT, 52 for SLP, or 53 for cardiac rehab.*)
12. **Plan of Treatment/Functional Goals** - Enter brief current plan of treatment goals for the patient for this billing period. Enter the major short-term goals to reach overall long-term outcome. Enter the major plan of treatment to reach stated goals and outcome. Estimate time-frames to reach goals, when possible.
13. **Signature** - Enter the signature (*or name*) and the professional designation of the professional establishing the plan of treatment.
14. **Frequency/Duration** - Enter the current frequency and duration of your treatment; *e.g.*, 3 times per week for 4 weeks is entered 3/Wk x 4Wk.
15. **Physician's Signature** - If the form CMS-700 is used for certification, the physician enters his/her signature. **If certification is required and the form is not being used for certification, check the ON FILE box in item 18.** If the certification is not required for the type service rendered, check the N/A box.
16. **Date** - Enter the date of the physician's signature only if the form is used for certification.
17. **Certification** - Enter the inclusive dates of the certification, **even if the ON FILE box is checked in item 18.** Check the N/A box if certification is not required.
18. **ON FILE** (Means certification signature and date) - Enter the **typed/printed name of the physician** who certified the plan of treatment that is on file at the billing provider. If certification is not required for the type of service checked in item 8, type/print the name of the physician who referred or ordered the service, **but do not check the ON FILE box.**
19. **Prior Hospitalization** - Enter the inclusive dates of recent hospitalization (*1st to DC day*) **pertinent** to the patient's current plan of treatment. Enter N/A if the hospital stay does not relate to the rehabilitation being rendered.
20. **Initial Assessment** - Enter only **current relevant history** from records or patient interview. Enter the major functional limitations stated, if possible, in objective measurable terms. Include only relevant surgical procedures, prior hospitalization and/or therapy for the same condition. Include only pertinent baseline tests and measurements from which to judge future progress or lack of progress.
21. **Functional Level** (end of billing period) - Enter the pertinent progress made and functional levels obtained at the end of the billing period compared to levels shown on initial assessment. Use objective terminology. Date progress when function can be consistently performed. When only a few visits have been made, enter a note indicating the training/treatment rendered and the patient's response if there is no change in function.
22. **Service Dates** - Enter the From and Through dates which represent this billing period (*should be monthly*). Match the From and Through dates in field 6 on the UB-92. **DO NOT** use 00 in the date. Example: 01 08 91 for January 8, 1991.