

PCR: \_\_\_\_\_ Date: \_\_\_\_\_

CLINIC NAME

ICD 10

Encounter Type	Home locations	SiteLocations	HostClinicLocations		
Trauma	Substance Abuse	Custody Status	Face to Face		
Date of Service	Service Mins	Date of Doc	Doc Mins	Trav Time	Non-bill Trav

Date ED entered _____ OT Initials _____
Date ED Corrected _____ OT Initials _____
ENCOUNTER LOCATION (If not clinic or PT's home)

Diagnosis/ Problem List Treated Today	Diagnosis/Prob. List not Treated Today	GROUP TREATMENT		
		# of Clients	# of Therapists	Co-Therapist Name
		BILLABLE CPT		
		NON-BILLABLE CPT /NON-COMPLIANT CPT		
		NON-BILLABLE TRAVEL CPT		
		OTHER CPT CODE		
Gen Med Conditions				
Language used				
Interpreter Utilized ? <input type="checkbox"/>		Clinician Credit Reason # _____ Date _____ Init _____ Credit reasons 1)MD sig (2) Clt. Sig (3) No MTP/CSP (4) Dup Svc (5) Other		

CPT MODIFIER I (Service Strategies)
CPT MODIFIER II (Evidence Based Practices)
CPT MODIFIER III -Add on codes
REPEAT SERVICES CORRECTIONS
<input type="checkbox"/> 59 Rpt Svc DDD <input type="checkbox"/> 76 Rpt Svc Same Provider <input type="checkbox"/> 77 Rpt Svc Diff Provider
Date Corrected _____ OT Initials _____

## PROGRESS NOTE

I authorize HCA to bill for services indicated on this fee sheet. I certify that the services shown on this document were furnished by me personally, that the services were medically necessary.

X

X

\* These services will be billed "For Denial Only" with CPT 90899-GY for Medicare and 3rd Party Insurance.  
\*\* These services will be billed "For Denial Only" with CPT 90899 for 3rd Party Insurance.

Delete and enter Clinician Name and Title.

Initial if not the last page: \_\_\_\_\_