DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION

(Complete for interim to Discharge Claims. Photocopy of HCFA-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 π PT π OT π SLP π CR π RT π PS π SN π SW	9. PRIMARY DIAGNOSIS (Pertinent Medical D.X.)		10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.
	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) OUTCOME (Long Term)	PLAN

I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. π N/A π DC		14. RECERTIFICATION FROM THROUGH π N/A
15. PHYSICIAN SIGNATURE	16. DATE	17. ON FILE (Print/type physician's name) π

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. π CONTINUE SERVICES *OR* π DC SERVICES

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

23. SERVICE DATES FROM THROUGH