|  |  |  |
| --- | --- | --- |
| Client:      | Client #:      | Program:      |
| Date of Service:      | Unit:      | Subunit:      | # of Clients:      |
| Server ID:      | Service Time:      | Travel Time:      | Documentation Time:       |
| Person Contacted:      | Place:      | Outside Facility:      | Appointment Type:      |
| Billing Type (Language Services Provided in:       | Intensity Type (Interpreter Utilized):      |
| Diagnosis At Service (This Client) ICD-10 Code(s):      | Service:      |
| **OVERVIEW OF GROUP****Document the global focus and intended outcome of the group intervention:** |
| **INDIVIDUAL GROUP SPECIFICS** |
| **COLLATERAL SERVER (Document the clinically compelling reason for a collateral server):** |
| **TRAVEL TO / FROM:** |
| **INTERVENTION (How does the service address the beneficiary’s behavioral health need(s) – symptoms, condition, diagnosis, and/or risk):** |
| **CLIENT RESPONSE (How did the client respond to the above intervention}:** |
| **NEXT STEPS (Planned action steps by provider or beneficiary, collaboration with beneficiary, collaboration with other providers(s), and/or update to problem list:** |

\***Signature/Title/Credential** **Date**  **Printed Name/Credential/Server ID#**

\*I certify that the service/s shown on this sheet were provided by me personally and the services were medically necessary.

**Co-Signature/Title/Credential Date Printed Name/Credential/Server ID#**