Logo Here

**DOCUMENTATION OF SERVICES RENDERED**

Eligible Recipient Name:       DOB:

<Patient/Client/Guest> Medicaid Number:

Referring Provider Name:       Referring Provider NPI:

Date of Service:       Location of Service:

CHW Providing the Service:       Begin time:       End Time:

Number of billable units:

|  |  |  |  |
| --- | --- | --- | --- |
| *16-45 minutes* | *1 Unit* | *46 minutes to 1:15 minutes* | *2 units* |
| *1:16 minutes to 1:45 minutes* | *3 Units* | *1:45 minutes or more* | *4 units* |

Number of Units to Submit for Billing:

Choose One:  Individual or  Group

If group, number in group *(documentation will be required for each billed individual within the group)*:

**Objectives Addressed *(Check all that apply):***

Assess and assist with social determinants of health needs related to qualifying condition(s) and/or

qualifying barrier(s).

Provide health system navigation and resource coordination related to qualifying condition(s)

and/or qualifying barrier(s).

Provide health promotion and coaching regarding qualifying condition(s) and/or qualifying

barrier(s) and subsequent social determinants of health needs.

Provide health education regarding qualifying condition(s) and/or qualifying barrier(s) and

subsequent social determinants of health needs.

Other:

X The patient/client/parent/legal guardian and/or CHW agency have identified barriers to video and audio telehealth communication.

**Description of services provided relating to the above objectives:**

**Diagnosis Codes for Billing:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary (1 in this column, required)** | **Secondary (up to 4 in this column, optional)** | **Z-Code** | **Description** |
|  |  | ZXXX | Code Description |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Date

Signature of Community Health Worker