



MANAGED CARE SERVICE RECORD and PROGRESS NOTE

CLIENT NAME _____

MR# _____

PROVIDER NAME/AGENCY _____

Date/Year of Service		Face to Face Mins (Client Present)	
CPT Code		Service Time (Client Not Present)	
Location Code		Language (if language services provided)	

Diagnosis Addressed: _____

Service Description: Goal/behavior addressed, therapist interventions, client's response/outcome, and plan.

Printed Name/Signature & License or Job Title of Clinician Providing Service/Writing Note

Date Signed

LOCATION CODES

- | | | | |
|---------------------------------|------------------------------------|---------------------------------|---|
| A - Office | H - Client's Home | Q - Missed Visit (non-billable) | X - Skilled Nursing Facility Psych (Lock) |
| B - Field (unspecified) | K - Vmail/Email/Fax (non-billable) | R - Residential Care - Children | Y - PES (Lockout) |
| D - Hospital/IMD/SNF | L - Residential Care - Adults | S - School | |
| E - Homeless/Emerg Shelter | P - Phone | T - Telehealth | |
| G - HealthFac/PCP/non-psych SNF | | W - IMD/MHRC (Lockout) | |