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Outcome and Assessment Information Set Home Health Patient Tracking Sheet

(M0010) C M S Certification Number: _____

(M0014) Branch State: __ __

(M0016) Branch I D Number: _____

(M0018) National Provider Identifier (N P I) for the attending physician who has signed the plan of care:

_____ UK – Unknown or Not Available

(M0020) Patient I D Number: _____

(M0030) Start of Care Date: ____/____/_____
month / day / year

(M0032) Resumption of Care Date: ____/____/_____
month / day / year NA - Not Applicable

(M0040) Patient Name:

(First) (M I) (Last) (Suffix)

(M0050) Patient State of Residence: __ __

(M0060) Patient Zip Code: _____

(M0063) Medicare Number: _____ NA – No Medicare
(including suffix)

(M0064) Social Security Number: _____ - _____ - _____ UK – Unknown or Not Available

(M0065) Medicaid Number: _____ NA – No Medicaid

(M0066) Birth Date: ____/____/_____
month / day / year

(M0069) Gender:

- 1 - Male
- 2 - Female

(M0140) Race/Ethnicity: (Mark all that apply.)

- 1 - American Indian or Alaska Native
- 2 - Asian
- 3 - Black or African-American
- 4 - Hispanic or Latino
- 5 - Native Hawaiian or Pacific Islander
- 6 - White

(M0150) Current Payment Sources for Home Care: (Mark all that apply.)

- 0 - None; no charge for current services
- 1 - Medicare (traditional fee-for-service)
- 2 - Medicare (HMO/managed care/Advantage plan)
- 3 - Medicaid (traditional fee-for-service)
- 4 - Medicaid (HMO/managed care)
- 5 - Workers' compensation
- 6 - Title programs (e.g., Title III, V, or XX)
- 7 - Other government (e.g., TriCare, VA, etc.)
- 8 - Private insurance
- 9 - Private HMO/managed care
- 10 - Self-pay
- 11 - Other (specify) _____
- UK - Unknown