# Treatment Plan Form

Submit via Fax to: 833-520-4880

Or via secure email: Operations_Delivery@ontrak-inc.com

**Suggested Clinical Components**

Goals of Treatment: _____

Objectives: _____

Methods: _____

**Administrative Components**

Member Name: _____

Member DOB: _____

Ontrak ID: _____

Service Date: _____

Session Number: _____

Rendering Provider Name: _____

Visit Type: ☐ Face-to-face ☐ Telehealth ☐ Telephonic

ICD-10 Diagnosis Code(s) (Must be a specified code): _____

Next Appointment Date and Time (when applicable): _____

Next Visit Type: ☐ Face-to-face ☐ Telehealth ☐ Telephonic

_____

Provider Signature

SUBMIT