A treatment plan is required for all members and submission must be by member’s third visit. All other visits require an updated treatment plan or visit summary, submitted within (3) business days after each visit.

**Submit via secure fax to 888-972-9589 OR via secure email to** [**operations\_delivery@ontrakhealth.com**](mailto:operations_delivery@ontrakhealth.com)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Service: |  | | | Time: | | |  | | Session: | | of | |
| Visit Type: | In Person | | Telehealth | | | Initial | | Follow-Up | | Therapy | Med Management | |
| Patient Name: |  | | |  | | | | DOB: |  | | Ontrak ID: |  |
|  | *Last* | | | *First* | | | |  | | | | |
| Provider Name: |  | | |  | | | | ICD-10 Diagnosis Codes: | | |  | |
|  | *Last* | | | *First* | | | | *F99/unspecified not accepted* | | | | |
| Next Appointment Date of Service: | |  | | | Time: | |  | | |  |  | |

|  |  |  |
| --- | --- | --- |
| Treatment Plan | Visit Summary | |
| *Goal(s), Objective(s) and Method(s)* | *Brief assessment of the patient including progress toward goals* | |
|  | |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |