PROVIDER NOTES FORM

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

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
Goal(s), Objective(s) and Method(s)

☐ Visit Summary
Brief assessment of the patient including progress toward goals

Signature: _____ Date: _____