1 Patient Information

1 PATIENT DETAILS

Name: _____

DOB: _____

Age / Sex: _____

Care Manager / Clinical Staff: _____

Care Setting: _____

Date of Service / Care Period: _____

Provider: _____

MRN: _____

Primary Care Provider: _____

RN Reason for Chronic Care Management

2 REASON FOR CCM ENROLLMENT

Chronic conditions being managed, complexity of care, risk of exacerbation, functional limitations, and need for ongoing care coordination...

AC Active Chronic Conditions

3 CHRONIC DIAGNOSES

List active chronic diagnoses — diabetes mellitus, hypertension, heart failure, COPD/asthma, CKD, coronary artery disease, depression/anxiety, chronic pain, other long-term conditions...

IH Interval History

4 UPDATES SINCE LAST CONTACT

Changes in symptoms or disease control. Recent exacerbations, urgent care, ED visits, or hospitalizations. Medication changes or adherence concerns. New diagnoses or complications. Patient-reported barriers. Changes in functional status, home environment, or caregiver support...

MR Medication Review

5 MEDICATION RECONCILIATION & ADHERENCE

Current medications reviewed, new/changed/discontinued medications, adherence concerns or side effects, refill needs, high-risk medications, interactions, monitoring requirements, patient understanding...

SM Self-Management Assessment

6 PATIENT SELF-MANAGEMENT

Symptom monitoring at home: _____

Diet / Exercise: _____

Medical equipment / monitoring devices: _____

Home readings (BP/glucose/weight/SpO2): _____

Smoking / Alcohol: _____

Patient confidence / understanding: _____

CC Care Coordination Activities

7 COORDINATION PERFORMED

Communication with physicians, specialists, pharmacies, home health, DME suppliers, caregivers. Scheduling/confirming appointments. Addressing transportation, cost, access, insurance, or health literacy barriers. Referrals, labs, imaging, preventive services...

CD Clinical Data Reviewed

8 REVIEWED DATA

Recent labs: _____

Imaging / diagnostic results: _____

Specialist notes: _____

Hospital or ED records: _____

Home monitoring data: _____

Preventive care status: _____

A Assessment

9 CHRONIC CARE STATUS INTERPRETATION

Current control/stability of each chronic condition. Risk of deterioration, exacerbation, or hospitalization. Barriers impacting disease management. Progress toward chronic care goals. Medical necessity for continued CCM...

CP Care Plan / Plan of Care

10 ONGOING CCM MANAGEMENT

Disease-specific management goals. Medication management plan. Monitoring parameters and target ranges. Lifestyle and self-management recommendations. Preventive care and screening needs. Referrals, follow-up appointments, or community resources. Escalation instructions for worsening symptoms...

PE Patient Education

11 EDUCATION PROVIDED

Disease process and warning signs, medication adherence, home monitoring technique, diet/exercise/smoking cessation, when to contact clinic or seek emergency care...

FU Follow-Up

12 NEXT CCM CONTACT

Next Care Management Contact: _____

Upcoming Appointments: _____

Items to Reassess: _____

TIME DOCUMENTATION & BILLING (CCM)

Total CCM Time This Calendar Month: _____ Clinical Staff Time: _____ Provider Time: _____ CPT Code(s) (99490/99439/99487/99489/99491): _____

Basis for Billing: _____ Primary ICD-10 Code: _____

Secondary ICD-10 Code(s): _____

PROVIDER / CARE MANAGER NAME	CREDENTIALS	DATE	TIME