685 River Ave.
Lakewood, NJ 08701
855-5-CHARTS • 732-523-7600

PDPM Minimum Data Set 3.0 Tracking Form

DIAGNOSIS CODING WORK SHEET

Resident's Name: _____ **Room #:** _____

Admission Date: _____ **Number of Medicare Days:** _____

Qualifying Hospital Stay _____ _____

Prior SNF Stay **within the last 60 days**_____

SKILLED SERVICES PROVIDED: _____

Date of Last Administration of the Following Services:

IV FLUIDS: _____

PRINCIPAL DIAGNOSIS:

Reason for Skilled Care _____

Admitting Diagnosis: _____

OTHER DIAGNOSES (WITH ICD-10 CODES):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ACTUAL PATIENT INFORMATION				
TYPE OF ASSESSMENT	A.R.D.	HIPPS CODE	BILLING DATES	
			START	END
5-DAY (Day 1 – 8)				
IPA				
INTERRUPTED STAY?				
			LAST COVERED DATE:	

Discharge Plan/Discharged to: _____**Home** _____ **Home w/ HHA** _____**Hospital** _____**AMA**

_____**Home Hospice** ____**Long Term Hospital** _____**Psych Hospital** _____**LTC**