MEDICARE
CARE PLAN OVERSIGHT (CPO)
Physician Tracking Form

HOME HEALTH

Patient Name:________________________ DOB: ___________________

CPO for Month of:__________________ Year: ____________________

<table>
<thead>
<tr>
<th>Activity</th>
<th>CPO Code</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Certification</td>
<td>GO180</td>
<td></td>
</tr>
<tr>
<td>Re-certification</td>
<td>GO179</td>
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<th>CPO Code</th>
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</table>

Develop Care Plan
Revise Care Plan
Coordinate Svcs
Documentation
Med Decision making
Review of: Charts, TX plans, labs, other tests
Communication w/ other health care professionals
Team Conferences
Med mngmt / adjustments; discussions w/ pharmacists (phone or face to face)
Other (describe)

Total monthly minutes: ____________ CPO (Time must total at least 30 minutes in a calendar month in order to bill Medicare)

Physician Signature:________________________ Date:___________________

Form courtesy of Providence Home Services