



Sending Caring Professionals to Your Home since 1994

Main office, Tel No. 310-329-4835

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CARE PLAN OVERSIGHT LOG SHEET

Patient Name: _____ DOB: _____ Agency Name: _____

Date (month/day/year)																Total Time with Patient
Development of Care																
Revision to Care Plan																
Review of Patient Reports																
Review (charts, treatment plans, lab or other test results)																
Adjustment of medication; New/Change medication																
Communication with Other Health Care Professionals																
Other (Define)																

Time spent must be equal to at least 30 minutes in a calendar month in order to bill Medicare.
 Activity & CPO Codes: **Recertification - G0179** **Initial Certification - G0180** **Care Plan Oversight - G0181**

Total Time:
(Monthly Minutes:)

Physician Signature: _____ Date _____

(Form must be signed by Physician)