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## Outcome and Assessment Information Set Home Health Patient Tracking Sheet

(M0010) C M S Certification Number: \_\_\_\_\_

(M0014) Branch State: \_\_\_\_

(M0016) Branch I D Number: \_\_\_\_\_

(M0018) National Provider Identifier (N P I) for the attending physician who has signed the plan of care:

\_\_\_\_\_ ☐ UK – Unknown or Not Available

(M0020) Patient I D Number: \_\_\_\_\_

(M0030) Start of Care Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
month / day / year

(M0032) Resumption of Care Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ ☐ NA - Not Applicable  
month / day / year

(M0040) Patient Name:

\_\_\_\_\_  
(First) (M I) (Last) (Suffix)

(M0050) Patient State of Residence: \_\_\_\_

(M0060) Patient Zip Code: \_\_\_\_\_

(M0063) Medicare Number: \_\_\_\_\_ ☐ NA – No Medicare  
(including suffix)

(M0064) Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ☐ UK – Unknown or Not Available

(M0065) Medicaid Number: \_\_\_\_\_ ☐ NA – No Medicaid

(M0066) Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
month / day / year

(M0069) Gender:

- ☐ 1 - Male  
☐ 2 - Female

**(M0140) Race/Ethnicity: (Mark all that apply.)**

- ☐ 1 - American Indian or Alaska Native
- ☐ 2 - Asian
- ☐ 3 - Black or African-American
- ☐ 4 - Hispanic or Latino
- ☐ 5 - Native Hawaiian or Pacific Islander
- ☐ 6 - White

**(M0150) Current Payment Sources for Home Care: (Mark all that apply.)**

- ☐ 0 - None; no charge for current services
- ☐ 1 - Medicare (traditional fee-for-service)
- ☐ 2 - Medicare (HMO/managed care/Advantage plan)
- ☐ 3 - Medicaid (traditional fee-for-service)
- ☐ 4 - Medicaid (HMO/managed care)
- ☐ 5 - Workers' compensation
- ☐ 6 - Title programs (e.g., Title III, V, or XX)
- ☐ 7 - Other government (e.g., TriCare, VA, etc.)
- ☐ 8 - Private insurance
- ☐ 9 - Private HMO/managed care
- ☐ 10 - Self-pay
- ☐ 11 - Other (specify) \_\_\_\_\_
- ☐ UK - Unknown