

Iowa Medicaid Enterprise-Medical Services Unit

Remedial Services –Service Documentation Requirements Checklist

Member Name: _____

Medicaid Number: _____

Number	SERVICE DOCUMENTATION	Date of service	Date of service	Date of service	Date of service	Date of service
1	Member name, Date of Birth and SID number at the top of each page					
2	Date of service					
3	Amount of services (# of units)					
4	Beginning and end times					
5	Service location					
6	Description of service (procedure code and/or description)					
7	Treatment plan goal					
8	Document specific skill provided					
9	Member’s response to treatment					
10	Treatment/services are remedial					
11	Treatment/services consistent with plan					
12	Participants in family units identified					
13	Non remedial note/s not included or clearly labeled					
14	Treatment/service revised as needed					
15	Name of staff with signature providing services					
16	Title of staff providing services					
17	Name of agency providing services					

Summary

Number of notes reviewed: _____

Number of notes remedial: _____

Number of notes consistent with the implementation plan: _____

Comments: