1st American Choice Home Services LLC

OASIS TRACKING SHEET

(M0010) CMS Certification Number: __ __ __ __ __ __ (485#5)

(M0014) Branch State: __ __ **(M0016) Branch I D Number**: __ __ __ __ __ __ __ __ __ __

Attending physician's name who will sign the Plan of Care**:** _____
(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 ID Number: __

(M0030) Start of Care Date: __ __ / __ __ / __ __ __ __ (485#2) **(M0032) Resumption of Care Date**:
month day year __ __ / __ __ / __ __ __ __ ❑ **NA - Not Applicable**
month day year

(M0040) Patient Name: (485#6)

_____ ____ _____ _____
(First) (MI) (Last) (Suffix)

Patient Address: _____
City**:** _____ **Location where services provided: ❑Patient's residence ❑ALF ❑Other**

(M0050) Patient State of Residence: __ __ **(M0060) Patient ZIP Code**: __ __ __ __ __ - __ __ __ __

Phone #: _____

(M0063) Medicare Number: __ __ __ __ __ __ __ __ __ __ __ __ (485#1) ❑ **NA - No Medicare**
(including suffix)

(M0064) Social Security #: __ __ __ - __ __ - __ __ __ __ ❑ **UK - Unknown or Not Available**

(M0065) Medicaid#: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ ❑ **NA - No Medicaid**

(M0066) Birth Date: __ __ / __ __ / __ __ __ __ (485#8)
month day year

(M0069) Gender: ❑ 1 - Male ❑ 2 - Female (485#9) **Marital Status:** ❑ Single ❑ Married ❑ Divorced ❑ Widowed

(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 (for example, Title III, V, or XX)
- ❑ 7 - Other government (for example, TriCare, VA)
- ❑ 8 - Private Insurance
- ❑ 9 - Private HMO/managed care
- ❑ 10 - Self-pay
- ❑ 11 - Other (specify) _____
- ❑ UK - Unknown

Signature/Title of discipline completing:_____ **Date:**_____

Signature/Title of discipline revising:_____ **Date:**_____

Signature/Title of discipline revising:_____ **Date:**_____