



HOSPITAL OT CHARGING SHEET

Patient: _____
 Account #: _____
 Therapist: _____

Schedule: _____
 Insurance: _____

Bill Code	Description	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
47100001	OT INITIAL EVAL	97003																
47100002	REASSESS / DC	97004																
47100029	GAIT TRAINING	97116																
47100016	THER-EX FXNL ACTIVITY	97530																
47100012	THER-EX STRENGTH/FLEXIBILITY	97110																
47100013	THER-EX NEURO/BAL/COORD/PROP	97112																
47100019	WHEELCHAIR MANAGEMENT	97542																
47100024	PROSTH TRAIN	97761																
47100034	ORTHOT TRAIN	97760																
47100018	SELF-CARE/HOME MANAGEMENT	97535																
47100003	HOT/COLD PAC	97010																
47100004	VASOPNEUMATIC DEVICES-JOBST PUMP	97016																
47100010	ULTRASOUND	97035																
47100025	E STIM (UNATTENDED)	97014																
47100005	PARAFFIN	97018																
47100014	MANUAL THERAPY (JT SOFT TISSUE MOB)	97140																
47100007	E STIM (ATTENDED)	97032																
47100017	COGNITIVE RETRAINING	97532																
47100009	CONTRAST BATH	97034																
47100033	COMMWORK REINTEGRATION	97537																
47100030	WOUND CARE	97139																
47100020	WOUND CARE DEBRIDEMENT	G0169																
47100037	IN ROOM THERAPY																	
47100032	SENSORY INTEGRATION	97533																
47100008	IONTOPHORESIS EACH 15 MINS.	97033																
47100036	NO CHARGE																	

THERAPEUTIC RECREATION DEPT CHARGE SHEET

Patient: _____
 Account #: _____
 Room #: _____
 Doctor: _____

Bill Code	Description	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
47100018	MEAL PREP																		
47100012	EXER-ROM																		
	NOT SEEN																		
47100036	NO CHARGE																		
VISITS																			