## McLAREN FLINT PARTIAL HOSPITALIZATION PROGRAM

## **PSYCHIATRIC VISIT RECORD** Physician / Billing Use Only

Patient Name (Last, First):			Hosp. Acct #:		
Admit Date:		D/C Date:	Insurance Type:		
Diagnosis Code	(primary):	_ Code (secondary): _			
INPATIE		PATIENT	PARTIAL HOSPITAL PROGRAM		
	Fax t	o Katie Patterson @ (	810) 342-3700 / p	hone: 342-4419	
Date / Year:	Physician	Comprehensive Evaluation 90801	Medication Review (sub) 90862	Half Session (20-30 min) with Med Review 90817	Half Session (20-30 minutes) 90816
		(2809069)	(2809051)	(2809036)	(2809044)
hysician Signatur	re/stamp:		Date:		



PT.

MR.#/RM.

DR.