SCHOOL-BASED HEALTH CENTER

Health Visit Report

SBHC Name and Address

SBHC Provider Number:
Contact Name:
Telephone:
FAX:

MCO Name and Address:

Contact Name:
Telephone:
FAX:

Student Name:
SBHC HX Number:
Address:

DOB:
MA Number:
SS Number:
Contact Name:
Contact Phone Number:

Date of Visit:

Type of Visit:
☐ EPSDT ☐ Acute/Urgent
☐ Other ☐ Follow-up

CPT Codes

ICD-9 Codes

Provider Name/Title: PRINT

Next SBHC Appointment:

Subjective:

Objective:

Assessment/Diagnosis:

Plan/Recommendation:

Provider Signature: _____

PCP's Name:
(if known)

PCP F/U Required ☐ Yes ☐ No

Number for more forms
and Identifier
Revised 12/14/01

410-767-1485, 1-877-463-3464 or ext. 1485