HealthCare Partners, IPA
HealthCare Partners, MSO

Basic Medical Record Documentation requirements:

- Demographic information must include patients name, DOB, address, home/work phone number and insurance information.
- Date of service and Patient's identifiers such as name and DOB must be on each page of the medical record. For HCC Risk Adjustment documentation review a face to face visit is required.
- All entries in the medical record must include Providers full name with signature and credentials.
- All documentation needs to be legible.
- Errors should be noted with a line strike through with initials and date.
- Progress note must include a comprehensive list of all significant illnesses and current medical conditions, and a past medical history section including all serious accidents surgeries and illnesses.
- Medication list must include documentation of any allergies and adverse reactions.
- Patients age 12 years and older, progress note should include appropriate screening for tobacco, alcohol, and substances.
- The subjective and objective information should be identified clearly in the documentation of history and physical exam.
- Each medical condition must be supported by documentation of status (eg: stable, worsening...etc.) and active treatment plan.
- Order labs, diagnostic studies, and refer to specialists appropriately. And obtain reports and consults (entire report/note s with all pages) to be placed in the PCP medical record.
- Continuity of care for ongoing medical issues needs to be documented in each visit until resolved.
- Include up to date Immunization records (both adults and children) and all preventive screenings and services performed as part of medical record in the PCP office.

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