

**Department of Physical Medicine & Rehabilitation**  
**UAMS Consultation Encounter Form**

**Patient Name:** \_\_\_\_\_  
**UAMS #:** \_\_\_\_\_  
**Referring Physician:** \_\_\_\_\_  
**Facility:** \_\_\_\_\_

**DOB:** \_\_\_\_\_  
**Date Seen:** \_\_\_\_\_  
**Insurance:** \_\_\_\_\_

**Initial Inpatient Consultation**

**Medicare (eff. 1/1/10) **& BCBS** (eff. 4/1/10)**

- \_\_\_ 99251 Problem focused
- \_\_\_ 99252 Expanded Problem focused
- \_\_\_ 99253 Detailed
- \_\_\_ 99254 Comprehensive – Moderate decision making
- \_\_\_ 99255 Comprehensive – High Complexity decision making

- \_\_\_ 99221 Detailed Initial Care with Low or Straight-forward decision making
- \_\_\_ 99222 Comprehensive Initial Care with Moderate decision making
- \_\_\_ 99223 Comprehensive Initial Care with High Complexity decision making

**Subsequent visit**

- \_\_\_ 99231 Problem focused
- \_\_\_ 99232 Expanded problem focused
- \_\_\_ 99233 Detailed

\_\_\_ *GC modifier Resident participation with consult (Medicare only)*

**Diagnosis**

- 1.
- 2.
- 3.
- 4.

- Will follow
- Not Appropriate
- Admit when stable
- \_\_\_\_\_

I certify that: (1) All services on this form were personally provided and/or personally supervised by me and are hereby approved for billing; (2) I understand that the medical records must be documented for these services; and (3) the rendering of the services and documentation for the medical record are in accordance with Faculty Group Practice guidelines.

\_\_\_\_\_  
Attending Physician/APN

\_\_\_\_\_  
Date