

<b>Member ID</b>	Each page in the record contains member name or member ID number.
<b>Signed entry</b>	All entries are signed or initialed (electronically) by the provider.
<b>Dated entry</b>	All entries are dated.
<b>Legibility</b>	The record is legible to someone other than the provider or provider's staff.
<b>Psychological assessment/ presenting problem</b>	A mental status examination is documented in the medical record. Presenting problems and relevant psychological and social conditions affecting the member's medical and psychiatric status are
<b>Medication list</b>	Prescribed medications and dosages are documented on a medication list.
<b>Allergies or adverse reactions</b>	Presence/absence of allergies or adverse reactions to medications are prominently noted. An absence of allergies should be clearly documented in the record.
<b>Tobacco use</b>	Use/nonuse of tobacco products is documented on members age 12 and older.
<b>Alcohol use</b>	Use/nonuse of alcohol is documented on members age 12 and older.
<b>Drug use</b>	Use/nonuse of illicit drugs is documented on members age 12 and older.
<b>Lab, diagnostic tests, and other studies</b>	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
<b>Working diagnosis</b>	There is a clearly documented diagnostic impression by the provider that is consistent with findings for each member visit.
<b>Plan of action/therapies/ treatment</b>	The provider initiating a treatment plan must describe the active target interventions with specific, measurable goals, and stated in behavioral
<b>Preventive services</b>	There is documentation of preventive services, as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes and referrals to community resources.
<b>Consultation/referrals/ continuity/coordination of care</b>	The medical record reflects continuity and coordination of care between the PCP, specialists, consultants, ancillary providers and healthcare institutions, as applicable. Discharge summaries are included, if applicable.
<b>Discharge plan</b>	If the member terminates treatment, documentation of a discharge plan is present.
<b>Care medically appropriate</b>	Medical record describes appropriate and necessary care, and there is no evidence of the member being placed at inappropriate risk. Record reflects that members who become homicidal or suicidal receive immediate and relevant interventions.
<b>Confidentiality</b>	Medical records contain confidentiality statements or a copy of signed consents to release information.