University of Louisville
Health Sciences Center
Office of Compliance

Auditing Department
502-852-4140

CHART REVIEW WORKSHEET
U of L HSC SCHOOL OF DENTISTRY

Provider Name: _____ Provider Type: _____
LAST FIRST

Date of Service: _____ Last Name: _____ ENC DOB _____

MRN _____ (IDENTIFIER)

Dept: DEN Division:_____ POS: _____ Payor: DOR DD HMD MET ATD MCR MCD Other: _____

Q/A By: _____

Date: _____

ACTION TO BE TAKEN

_____ RELEASE

_____ RELEASE W/ CORRECTIONS

_____ NO BILL

POINTS: _____

NC CODE: _____

ENTERED: _____

Auditor initial below:

_____AB _____HG

_____TB _____DT

_____JC _____SW

_____LC _____

Date:

_____

Teaching provider signature? YES NO

Date of service matches billing? YES NO

X-ray ordered? YES NO

-**Results documented?** YES NO

Material(s) used documented? YES NO

FOR MEDICAL SERVICES:

Surgery – teaching provider presence documented? YES NO

New Pt 3 of 3 YES NO

Estab Pt 2 of 3 YES NO

Consultation
Request YES NO
TP Opinion YES NO
Written Reply YES NO

Time documented: _____ min.

CODE(S)/MOD(S) SUBMITTED

CDT/CPT	Tooth/area	MOD	ICD-9	COMPLIANT	CORRECTIONS NECESSARY* CDT/CPT	Tooth/area	MOD	ICD-9
				YES NO				
				YES NO				
				YES NO				
				YES NO				
				YES NO				
				YES NO				
				YES NO				
				YES NO				

With Resident? YES NO **With Student?** YES NO

CCI EDITS REVIEWED YES NO LCD REVIEWED YES NO

CCI CORRECTION(S)* YES NO LCD CORRECTION(S)* YES NO

MCR SERVICES ONLY:
Teaching Mod Req.? YES NO **Submitted**: GC NONE **ADD GC TO FINAL CLAIM?** YES NO

***Comments/Corrections**:*

_____

_____

_____

Annual 90 Day 60 Day 90 Day F/U

Focused Investigative Other: _____

Services were:

Pre-Bill or Post-Billed**

*****Please note if claim corrections are needed!***