

Case Note-Billing Incongruence

Due Date: _____

Clinician: _____ Date of Review: _____ Reviewer: _____

| Client and ID | Date/Time/Type and Length of Service Billing | Date/Time/Type and Length of Service on Case Note | Planned Correction | Who will Correct |
|---------------|--|---|--------------------|------------------|
| | Date Time Length Type | Date Time Length Type | | |
| | Date Time Length Type | Date Time Length Type | | |
| | Date Time Length Type | Date Time Length Type | | |
| | Date Time Length Type | Date Time Length Type | | |
| | Date Time Length Type | Date Time Length Type | | |

Note: You have 5 business days to correct the incongruence and return this form to the person who generated it. If you do not complete the corrections in this time frame, your administrative supervisor will be notified.

By signing this form I certify that the above listed incongruence have been corrected and forward to the proper person.

Clinician's Signature: _____ Date: _____