

Case Note Incongruence Form

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	Expected Correction	Who Should Correct
	Date Time Length Type	Date Time Length Type	<input type="checkbox"/> Re-dictate Audio Missing (MIS was unable to recover)	<input type="checkbox"/> _____
			<input type="checkbox"/> Time Incongruence	<input type="checkbox"/> Billing Dept
			<input type="checkbox"/> Service Type Incongruence	<input type="checkbox"/> Billing Dept
			<input type="checkbox"/> Date of Service/Date Billed Incongruence	<input type="checkbox"/> Billing Dept
			<input type="checkbox"/> No Service/Refund	<input type="checkbox"/> Clinician/Billing
			<input type="checkbox"/> Other _____	<input type="checkbox"/> _____
	Date Time Length Type	Date Time Length Type	<input type="checkbox"/> Re-dictate Audio Missing (MIS was unable to recover)	<input type="checkbox"/> _____
			<input type="checkbox"/> Time Incongruence	<input type="checkbox"/> Billing Dept
			<input type="checkbox"/> Service Type Incongruence	<input type="checkbox"/> Billing Dept
			<input type="checkbox"/> Date of Service/Date Billed Incongruence	<input type="checkbox"/> Billing Dept
			<input type="checkbox"/> No Service/Refund	<input type="checkbox"/> Clinician/Billing
			<input type="checkbox"/> Other _____	<input type="checkbox"/> _____
	Date Time Length Type	Date Time Length Type	<input type="checkbox"/> Re-dictate Audio Missing (MIS was unable to recover)	<input type="checkbox"/> _____
			<input type="checkbox"/> Time Incongruence	<input type="checkbox"/> Billing Dept
			<input type="checkbox"/> Service Type Incongruence	<input type="checkbox"/> Billing Dept
			<input type="checkbox"/> Date of Service/Date Billed Incongruence	<input type="checkbox"/> Billing Dept
			<input type="checkbox"/> No Service/Refund	<input type="checkbox"/> Clinician/Billing
			<input type="checkbox"/> Other _____	<input type="checkbox"/> _____

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.

Responsible Staff Signature: _____ Date: _____