SITE:_____ Review one Medicaid, one Insurance, and one Self Pay

Program: _____ **Date Range:** _____ **Patient ID and Date of Service**	Family Size	Total annual income	Documented Percentage of Pay	Client/Interviewer Signed and dated	Was correct date of service entered?	Were all services entered as indicated on encounter?	Were services entered that were not on the encounter?	Sliding Fee Scale applied Correctly	Patient Charged Appropriately	**Key** ✓ = Yes, this is correct X = No, this is incorrect/not present N/A = Not Applicable (if no paper encounter) **Comments**
Medicaid	N/A	N/A	N/A	N/A				N/A	N/A	Paid by Medicaid? Or rebilled if denied?
Insurance										Paid by Insurance? Balance to Patient on SFS?
(1)										
(2)										
(3)										

Program: _____ **Date Range:** _____ **Patient ID and Date of Service**	Family Size	Total annual income	Documented Percentage of Pay	Client/Interviewer Signed and dated	Was correct date of service entered?	Were all services entered as indicated on encounter?	Were services entered that were not on the encounter?	Sliding Fee Scale applied Correctly	Patient Charged Appropriately	**Key** ✓ = Yes, this is correct X = No, this is incorrect/not present N/A = Not Applicable **Comments**
Medicaid	N/A	N/A	N/A	N/A				N/A	N/A	Paid by Medicaid? Or rebilled if denied?
Insurance										Paid by Insurance? Balance to Patient on SFS?
(1)										
(2)										
(3)										

Program: _____ **Date Range:**_____ **Patient ID and Date of Service**	Family Size	Total annual income	Documented Percentage of Pay	Client/Interviewer Signed and dated	Was correct date of service entered?	Were all services entered as indicated on encounter?	Were services entered that were not on the encounter?	Sliding Fee Scale applied Correctly	Patient Charged Appropriately	**Key** ✓ = Yes, this is correct X = No, this is incorrect/not present N/A = Not Applicable **Comments**
Medicaid	N/A	N/A	N/A	N/A				N/A	N/A	Paid by Medicaid? Or rebilled if denied?
Insurance										Paid by Insurance? Balance to Patient on SFS?
(1)										
(2)										
(3)										

Telemedicine Billing Review **Program: _____** **Date Range: _____** **Patient ID and Date of Service**	Family Size	Total annual income	Documented Percentage of Pay	Client/Interviewer Signed and dated	Was correct date of service entered?	Were all services entered as indicated on encounter?	Were services entered that were not on the encounter?	Sliding Fee Scale applied Correctly	Patient Charged Appropriately	**Key** ✓ = Yes, this is correct X = No, this is incorrect/not present N/A = Not Applicable **Comments**
Medicaid	N/A	N/A	N/A	N/A				N/A	N/A	Paid by Medicaid? Or rebilled if denied?
Insurance										Paid by Insurance? Balance to Patient on SFS?
(1)										
(2)										
(3)										
340B Billing Review (3 Medicaid) **Program: _____** **Date Range: _____** **Patient ID and Date of Service**	Family Size	Total annual income	Documented Percentage of Pay	Client/Interviewer Signed and dated	Was correct date of service entered?	Were all services entered as indicated on encounter?	Were services entered that were not on the encounter?	Sliding Fee Scale applied Correctly	Acquisition Cost charged Appropriately to Medicaid?	**Key** ✓ = Yes, this is correct X = No, this is incorrect/not present N/A = Not Applicable **Comments**
Medicaid	N/A	N/A	N/A							
(1)										
(2)										
(3)										