SITE:_____ Review one Medicaid, one Insurance, and at least 3 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 **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)										
(4)										
(5)										
(6)										

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?
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(1)										
(2)										
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