

QI0501-09/07

Patient Chart Review Report Audit Form

Patient Name				Date		
Type of Equipment/Service						
PROOF OF DELIVERY TICKET	<input type="checkbox"/> Client Name Accurate	<input type="checkbox"/> Address completed and accurate	<input type="checkbox"/> Description of products completed	Notes		
INTAKE FORM	<input type="checkbox"/> Client Name Accurate	<input type="checkbox"/> Responsible Party info complete	<input type="checkbox"/> Client Address Accurate	<input type="checkbox"/> Pertinent Diagnosis Info Complete	<input type="checkbox"/> Payer Information Complete	<input type="checkbox"/> Date of Birth Complete
INVOICES/CLAIMS	<input type="checkbox"/> Invoices/claims on file for correct dates of service			Notes		
RECEIPTS/EOB	<input type="checkbox"/> EOB for payment from Patient/Ins/Medicare Carriers Present				Notes	
List Any Other Irregularities Found or Expand upon the absence of a check off from above						

Monthly Audit Review Schedule by Patient Last Name			
January-March A-F	April-June G-L	July-September M-R	October-December S-Z

Auditor Name: _____