

Pt.- Name: _____ Chart #: _____ Audit Date: _____

DOS: _____ Auditor: _____

Place of Service: CIH Dental Clinic Emergency/ Scheduled Visit

Provider: _____

Codes Selected by Provider: _____

Code(s) Billed: _____

Code(s) Corrected: _____

Comments: _____

Provider Signed Progress/Encounter Form: Yes / No

X-Rays Ordered: Yes / No

X-rays in Chart: Yes / No