Business Office Use Only
14-Digit Medi-Cal Number

San Bernardino County

DEPARTMENT OF BEHAVIORAL HEALTH

STATE PRE-AUDIT CHART REVIEW AUDIT TOOL

ONE CLIENT PER FORM

Clinic Name: _____ **Reporting Unit:** _____

Client Name: _____ **Client Number:** _____

Birth Date: _____ **Date Reviewed:** _____

STANDARD	YES	NO	COMMENTS
1. Clinical Assessment completed 60-days from date of opening.	☐	☐	
2. Client Plan covering audit period _____ to _____ completed at appropriate time (in intake period, within one month for added services, or annually)	☐	☐	
3. Client Plan signed by provider for all modalities provided (list modalities not covered)	☐	☐	
4. Client Plan signed by client or person responsible	☐	☐	
5. Diagnosis is Medi-Cal-acceptable	☐	☐	
6. If TBS services are provided, there is a TBS plan	☐	☐	
7. Was Progress Note present?	☐	☐	
8. ID notes all signed by provider	☐	☐	
9. Group ID notes properly apportioned (number of clients is listed)	☐	☐	

CHARGE DATA AUDIT DISALLOWED

Service Date	Procedure Code	Group Count	Primary Staff Number	Primary Staff Time	Co-Staff Number	Co-Staff Time	Reason SAA = Same A Above
				:		:	
				:		:	
				:		:	
				:		:	
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Please Check One: ☐ **No Disallowances Found** ☐ **Recommendation To Disallow**

Chart Reviewed by: _____ _____

Signature Please Print Name

Disallowances Reviewed by: _____ _____

Clinic Supervisor/CT II Signature Please Print Name

Authorizing Signature: _____ **Date:** _____

Outpatient Review Coordinator

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