VIRTUAL VISIT REVIEW

Date of Service:	
Provider:	
Patient MR #:	
Original Code:	
Authorization / consent documented?	☐ Yes ☐ No
Method / Type of visit identified?	☐ Yes ☐ No
Insurance coverage verified?	☐ Yes ☐ No
Note identifies:	
Date of call	☐ Yes ☐ No
Reason/Rationale for visit	☐ Yes ☐ No
Location of the patient	☐ Yes ☐ No
Type of virtual visit	☐ Yes ☐ No
History	☐ Yes ☐ No
Time(s) of visit	☐ Yes ☐ No
Assessment and Plan	☐ Yes ☐ No
Does record justify the:	
Diagnosis	☐ Yes ☐ No
Orders and Testing	☐ Yes ☐ No
Reviewer Code:	
Comments:	