

RURAL PROVIDER RECORD COVER SHEET

Information must be complete before review process will begin

* Completed by Referring Provider

** Completed by Reviewing Provider

<p>* Unique Record ID: (Provider assigned sequential number)</p>	<p><i>If case is being resubmitted, add an "A" to the end of the Unique Record ID (100-0001A)</i></p>
<p>* Hospital Review Date:</p>	
<p>* Sanitize Record Time: (Optional)</p>	
<p>* Hospital URC Review Time:</p>	
<p>* Referral Reason:</p>	<p><input type="checkbox"/> Utilization (UR) <input type="checkbox"/> Quality <input type="checkbox"/> Both UR and Quality <input type="checkbox"/> Routine Peer Review</p>
<p>* Case Type:</p>	<p><input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> OB-GYN <input type="checkbox"/> Pediatrics</p>
<p>* Specialist</p>	<p><input type="checkbox"/> Yes - Specialty _____ <input type="checkbox"/> No</p>

Completed by Reviewing Provider:

<p>** Received Date:</p>	
<p>** Physician Review Date:</p>	
<p>** Physician Review Time:</p>	

Completed by Business Linx:

<p>Received Date from Referring Provider:</p>	
<p>Forwarded Date to Peer Review Provider:</p>	
<p>Received Date from Reviewing Provider:</p>	
<p>Returned Date to Referring Provider:</p>	

If you have questions concerning this review, please contact Kim Granfor, Business Linx, 701-224-9528.

Please complete the peer review and return to Business Linx by: _____

