**Internal UR Minutes from:**

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**(Agency Name/Program)**

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**(Month/Year)**

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| **name of Reviewer & tITLE** | **Client I.D.#** | **Medical NeceSsITY**  **Y/N** | **dx**  **consistent**  **Y/N** | **icd-10 code used**  **y/n** | **Problem List (if applicable)**  **Y/N** | **CA ASAM ASSESSMENT**  **Y/N** | **CARE PLAN (IF APPLICABLE)**  **Y/N** | **MISSING**  **SERVICE NOTES**  **Y/N** | **NARRATIVE CORRECTIVE ACTIONS**  **(MCFLOOPS)**  **Include letter and number from MCFLOOPS** |
| Click here to enter text | Click here to enter text | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N | Click here to enter text |
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**Signature (QI/QA, Lead Staff):**

**Signature (LPHA/LPHA Waived):**