**Internal UR Minutes from:**

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| Click here to enter text |

**(Agency Name/Program)**

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| Click here to enter text |

**(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):**