SD EForm - 0103 V2

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HELP

SOUTH DAKOTA CHIROPRACTIC PEER REVIEW

JOSEPH N. CARR, DC, DACRB
Executive Chairman Peer Review
MARCIA WALTER
Executive Secretary Peer Review
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REVIEW COMMITTEE INFORMATION SHEET
SDCPR Form #200

1. Request for review submitted by:

- ○ A. Attending Chiropractor
- ○ B. Third Party Carrier
- ○ C. Patient
- ○ D. Gov't Agency
- ○ E. Worker's Comp
- ○ F. Primary Ins.

2. Reason for submission to review committee:

3. Patient's name: _____ Age _____ Sex M ○ F ○

_____ _____ SD _____

Address: City State Zip

Relationship to insured: _____

4. Type of service(s) rendered (in detail, including complications):

5. Total fee(s) charged for services: _____

6. Action to date with respect to settlement of case:

7. Any additional information:

8. Chiropractor's supporting comments:

9. Chiropractor's Name: _____

SD

Address: City State Zip

10. Type of Insurance Coverage: _____

11. Name and address of third party reimbursement organization:

_____

SD

Address: City State Zip

12. Claim submitted by: _____
Title: _____

13. Date: _____ Telephone _____

1. PRINT FOR MAILING CLEAR FORM