SOUTH DAKOTA CHIROPRACTIC PEER REVIEW

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REVIEW COMMITTEE INFORMATION SHEET
SDCPR Form #200

1. Request for review submitted by (check one)
   A. Attending Chiropractor _____ D. Gov't Agency _____
   B. Third Party Carrier _____ E. Worker's Comp _____
   C. Patient _____ F. Primary Ins. _____

2. Reason for submission to review committee: _____
_____
_____

3. Patient's name: _____ Age _____ Sex ____
   Address: _____
   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:_____
   Address: _____

10. Type of Insurance Coverage:_____

11. Name and address of third party reimbursement organization:_____
_____

12. Claim submitted by: _____
    Title: _____

13. Date: _____ Telephone (_____) _____

(PLEASE INCLUDE AUTHORIZATION FOR RELEASE OF INFORMATION)