

Case Management URC Record

Program Name: _____ URC Date: _____

Client Name: _____ Admission Date: _____

Client S#: _____

Primary Diagnostic Impression and Justification on Date of UR:

Axis I or Axis II:

Chart documents Medical Necessity:

_____ Yes _____ No

Comments:

Chart documents Service Necessity:

_____ Yes _____ No

Comments:

Recommended Level of Case Management Services:

Discharge Plan/Other Service Recommendations:

Name of person reviewing chart

Signature