EL DORADO COUNTY
HEALTH AND HUMAN SERVICES AGENCY

Substance Use Disorder Services DMC-ODS
Service Verification Report Form

To: El Dorado County DMC-ODS QA	From:
Fax # 530-295-2596	Fax #
Today's Date:	Report Month:

Instructions for completing the report:

- ✓ Calculate total number of face-to-face client services in the report month (Box A)
- ✓ Calculate number of SVCs completed (Box B)
- ✓ Calculate minimum number (at least 5%) of services required to be verified. (Box C)
  - o Box A total X 0.5 = minimum number of services. Enter this number into Box C
- ✓ Enter number of services validated (Box D)
- ✓ Enter number of services completed by validator which were found to be out of compliance (Box E)
- ✓ Denote if County was notified if fraudulent claims were discovered (Box F)
- ✓ Denote if claim errors were processed for deletion from invoice (Box G)

Upon completion of report fax to phone number (530) 295-2596

A	B	C	D	E	F	G
# of face to face client services	# of SVCs completed	Minimum # of service require validation (min. 5%)	# of services validated	# of services out of compliance	Was County notified if fraudulent claims discovered?	Were out of compliance services deleted from invoice?
					☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A

Report completed by: ____

Signature, Print Name and Date

Official County Use Only: (Box C Total _____) – (Box D Total _____) = Total # of validated SVC needed to be in compliance (Box H)_____ Box H is =< 0 = compliance Box H is > 0 = out of compliance	Compliant? Yes No	County Reviewer Signature and Date: ___________________________