Date: ____________________________

Dear Dr. ____________________________:

In responding to this query, please exercise your independent professional judgment. The fact that a question is asked does not imply that any particular answer is desired or expected. We greatly appreciate your clarification on this issue.

Coder’s Name: ___________________________ Coder’s Phone #: ____________________________

Patient Name: ________________________________________________________________________

Admit Date: __________ Discharge Date: ______________

MR#: __________________ Acct #: __________________

The medical record reflects the following clinical findings (include reference to source document):

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Please respond to the following question:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

PHYSICIAN RESPONSE:

☐ Yes – [If yes, please document your response (i.e., condition, procedure, organism) in the space below and in the body of the medical record (progress notes, dictated report or as an addendum to a dictated report).]

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Physician Signature ___________________________ Date ___________________________

☐ No – [If no, please initial in or check the box, and sign and date below. This form will need to be maintained with the medical record.]

Unable to determine – [If so, please initial in or check the box, and sign and date below. This form will need to be maintained with the medical record.]

____________________________________________________________________________________

Physician Signature ___________________________ Date ___________________________