Submit by E-mail

POTENTIAL QUALITY OF CARE ISSUE(S) (PQI)

Intake Form

NAME OF PQI REFERRAL: _____ DATE REFERRED TO PQI: _____

CONTACT NUMBER/E-MAIL _____ DATE OF SERVICE / EVENT _____

REFERRAL SOURCE ----Internal Submissions

☐ Appeals Case # _____ Date Received: _____ ☐ Case Management

☐ Grievance Case # _____ Date Received: _____ ☐ Utilization Management

☐ Call Center ☐ Other ☐ Behavioral Health

Member's MRN: _____ Last Name: _____ First Name: _____

MEMBER INFORMATION ---- External Non-CCHP Submissions

Last Name: _____ First Name: _____ Member's MRN: _____

Date of Birth: _____ ☐ Medi-Cal # _____ ☐ Medicare # _____ ☐ CCHP # _____

Additional Information (i.e., Special needs, Veteran)

Other

FOCUS OF PQI (WHO WAS INVOLVED? WHERE DID THE ISSUE / INCIDENT HAPPEN?)

☐ Physician / Practitioner ☐ IPA / PPG ☐ Hospital* ☐ Facility*

☐ Others* *Identify Name of Entity Involved: _____

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PHYSICIAN / PRACTITIONER INFORMATION FOCUS OF PQI

Provider Last Name:_____ First Name:_____

Brief Summary of Issue / Incident: (In 1250 characters or less)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please include answers to all questions. Our team may be unable to process the PQI submission if these questions are not answered.

1. What is the main issue / incident?

_____
_____
_____

2. What is the impact to the member's clinical care?

_____
_____

3. What actions have been taken?

_____
_____

4. What is the current state of the member's condition?

_____
_____

For External Referrals: Please attach ANY pertinent information (i.e., Medical Records, Utilization Review Notes, etc.).

Please send all correspondence via Encrypted E-mail to: QualityConcerns@cchealth.org

Internal and External Referrals - Please Respond to ALL questions on this page.

External Submissions - Please Fill Out ALL PAGES.