Potential Quality Issue Referral Form

Date of Submission:	

Person Completing the Referral	
Name and Title	**Phone**
Health Network (if applicable)	**Email**
Provider's Information (Who is the PQI against?)	
Name and Credentials (M.D., D.O., NP, etc.)	**Phone**
Address (location of incident)	**Provider's NPI:**

Member's Information (if applicable)		
Last Name		**First Name**
CIN	**DOB MM/DD/YYYY**	**Date of Incident** (When did this occur?) **MM/DD/YYYY**
Has the member been contacted regarding this issue?		☐ Yes ☐ No If yes, when? MM/DD/YYYY: _____

What, if any, interventions have been initiated to assist the member?
Summary of the issue or concern, including pertinent clinical information.

What is the concern; what do you believe needs to be investigated? Select only one.		
☐ Access to Care ☐ Authorization Issue ☐ Behavioral Health ☐ Communication/Behavior	☐ Death ☐ Hospital Related ☐ Medical Care ☐ Medication Issue	☐ Other (including documentation and abuse) ☐ Provider Preventable Condition ☐ Surgery/Invasive Procedure ☐ Transportation

Please email the completed form to qualityofcare@caloptima.org or fax it to **657-900-1615.**

Please remember that once we begin an investigation, State of California peer review laws prohibit CalOptima Health from sharing details of the investigation.