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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Review:** 66/10/2020\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referral Audit 1st CAP Notification Letter | | | | | | | | | | |
| **Health Plan Performing Evaluation:** |  | | |  | |  | |  | |  |
| Reviewer’s Name/Title (Print): | | | | Reviewer’s signature/Title: | | | | | | |
| Facility Name: | | | PCP Name(s): | | | | | | # of Referrals Reviewed: | |
| Address: | | | | | Contact Person and Title: | | | | | |
| Telephone: | | Fax: | | | | | | | | |
| Referral Audit Score: | | **Date CAP Due:** | | | | | **Date of Re-assessment:** | | | |
|  | |  | | | | |  | | | |

Corrective Action Plan (CAP) Completion and Submission Requirements

#### Disclosure and Release

I have received and reviewed copies of the above listed evaluation and corrective action plans for the referral audit. I agree to correct each identified deficiency by implementing any corrective action that may be required. I understand that failure to correct any of the noted deficiencies within the required 30 calendar day time period from the review date, may result in the exclusion of this facility and the associated provider(s) from the roster. The completed CAP must include evidence of correction {e.g. a tracking log or process used to track referrals} and dates completed.

For assistance in completing the CAP, please call \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RN at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Designee Signature Printed Name and Title Date

Please Return Completed CAP via U.S. Mail or FAX to: Inland Empire Health Plan

Quality Management Department

P.O. Box 1800, Rancho Cucamonga, CA 91729-1800

Fax: (909) 890-5746 Attention: QM Coordinator