QUALITY MANAGEMENT (QM) POTENTIAL QUALITY ISSUE (PQI) REFERRAL
***Required Field**

DATE: _____ Print, complete and FAX this form to the TriWest QM Confidential FAX at 1-866-312-5838

BENEFICIARY PLAN ☐ PRIME ☐ STANDARD ☐ TFL ☐ TPR ☐ SHCP			
PATIENT NAME*: First, Middle Initial, Last		**DATE OF BIRTH:**	**SEX:** ☐ Male ☐ Female
SPONSOR SSN*: **PATIENT SSN*:**		**TYPE OF ADMIT:** ☐ Med/Surg ☐ Psych ☐ Ambulatory ☐ Partial Hospital Program Surgery ☐ Residential Treatment Ctr. ER Admit Yes☐ No☐	
PATIENT STATUS ☐ INPATIENT ☐ OUTPATIENT		**DATE PQI OCCURRED*:** DATE PQI IDENTIFIED*:	
PROVIDER NAME*: Last, First, Middle Initial PROVIDER TYPE* ☐ Network ☐ Non-network ☐ MTF		PROVIDER TIN# OR SSN*:	
FACILITY ADMITTED TO*:		FACILITY TIN#*: ☐ NETWORK ☐ NON-NETWORK	
ADMIT DATE:		DISCHARGE DATE:	
TRANSFERRED TO (FACILITY): TRANSFER DATE:		READMIT DATE/DOS: READMIT DC DATE/DOS:	

POTENTIAL QUALITY ISSUE CATEGORY/PATIENT SAFETY EVENT

SELECT INDICATOR*: ☐ Inefficient Care ☐ Surgical ☐ Patient Protection ☐ Quality of Care ☐ Product, Device, Drug, Biologic ☐ Environmental ☐ Deviation/Standards ☐ Care Management ☐ Criminal ☐ Does not meet Criteria

DIAGNOSIS & REASON FOR PQI REFERRAL*:
Note: *Please be as specific as possible.*

Name & Title:	**Referral Source** ☐ MTF#_____ DMIS Code ☐ TRO-West ☐ ALASKA ☐ TMA ☐ _____	**Phone Number:** **( ) -** Extension:

Confidential

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