POTENTIAL QUALITY OF CARE (PQOC)

Concern Referral & Investigation | *(Provider)*

UMPQUA HEALTH

Intake Information:

Referral Date: Referred by:

Referral Submitter's Name:

Organization:

Member Information:

First Name: Last Name:

OHP Member ID#: Date of Birth *(MM/DD/YYYY)*:

Practicioner/ Provider/ Facility Information:

Clinic Name: Provider's Name:

Credentials: ☐ MD/DO ☐ PA ☐ NP ☐ Other:

Specialty:

NPI/TIN: Network Status: ☐ In Network ☐ Out of Network

Was more than one practitioner involved?

Include any additional information:

Phone: 541-229-4842
Toll free: 866-672-1551
TTY: 541-440-6304 | 711

Email: *Qualityofcareconcern@umpquahealth.com*

Website: *www.umpquahealth.com*

Address:
3031 NE Stephens Street,
Roseburg, OR 97470

Quality of Care Category:

- ☐ a). Received appropriate care, but experienced an adverse outcome, complications, misdiagnosis, or concern related to provider care.
- ☐ b). Testing / assessment insufficient, inadequate, or omitted.
- ☐ c). Concern about prescriber or medication or medication management issues (prescribed non-formulary medication, unable to get prescription filled or therapeutic alternative recommended by Provider or Plan).
- ☐ d). Member neglect or physical, mental, or psychological abuse.
- ☐ e). Provider office unsafe/unsanitary environment or equipment.
- ☐ f). Lack of appropriate individualized setting in treatment.

Investigation:

CIM Case #:

Initial review findings:

Case Information:

Provide a brief description of the event/concern and include the date, where did it take place, who was involved and why do you think it happened:

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