

PQI Notification Form

Member's Name:		Date of Birth:	Health Plan/J.D.#:
Date Submitted:		Submitted By:	Department:
Group Name:		Provider Name:	Provider Phone Number:
CONTACT TYPE			
<input type="checkbox"/> Incoming Call	<input type="checkbox"/> Fax	<input type="checkbox"/> Email	<input type="checkbox"/> Letter
MEDICAL RECORDS ATTACHED		DESCRIBE EVENT	
<input type="checkbox"/> Face Sheets <input type="checkbox"/> Admission Summary <input type="checkbox"/> History and Physical <input type="checkbox"/> Consultations Reports <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Diagnostic Reports / Labs / X-Rays <input type="checkbox"/> Emergency Room Records <input type="checkbox"/> Hospital Progress Notes <input type="checkbox"/> Medication Sheets <i>(if applicable)</i> <input type="checkbox"/> Operative Reports <i>(if applicable)</i> <input type="checkbox"/> Wound Care Record <i>(if applicable)</i> <input type="checkbox"/> Other:			
Individual Submitting PQI / or Supervisor Signature:		Date:	

For questions, you can contact the Arizona Priority Care Quality Department at (480) 499-8700, Ext. 8152.

CONFIDENTIAL

This document shall be protected from discovery and provided the confidentiality imparted by the statutes of the Arizona Health & Safety Code 1
Revised Statutes A.R.S. § 36-2401 – 2404 and 36-445 – 445.03