Arizona Priority Care™
One Goal. One Priority. Your Healthcare.

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			
☐Incoming Call	☐Fax	☐Email	☐Letter

MEDICAL RECORDS ATTACHED	**DESCRIBE EVENT**
☐ Face Sheets ☐ Admission Summary ☐ History and Physical ☐ Consultations Reports ☐ Discharge Summary ☐ Diagnostic Reports / Labs / X-Rays ☐ Emergency Room Records ☐ Hospital Progress Notes ☐ Medication Sheets *(if applicable)* ☐ Operative Reports *(if applicable)* ☐ Wound Care Record *(if applicable)* ☐ 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 Revised Statutes A.R.S. § 36-2401 – 2404 and 36-445 – 445.03

AZPC; 04/2019