|  |  |  |
| --- | --- | --- |
| **Date of Review:** | **Surveyor:** | |
| **Name of IPA:** | | **IPA Code** |
| **Address:** | | |
| **City/State** | | |
| **Phone:** | | **FAX:** |
| **Name of Management Company (if applicable)** | | |
| **Address:** | | |
| **City/State:** | | |
| **Phone:** | | **FAX:** |
| **Name of Parent Company (if applicable)** | | |
| **Address:** | | |
| **City/State:** | | |
| **Phone:** | | **FAX:** |
|  | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **IPA Contact Personnel** | | **Phone** | **FAX** | **E-Mail** |
| **IPA Administrator** | |  |  |  |
| **Medical Director:** | |  |  |  |
| **QM Chairperson:** | |  |  |  |
| **QM Contact/Title:** | |  |  |  |
| **UM Chairperson:** | |  |  |  |
| **UM Contact/Title:** | |  |  |  |
| **CM Contact/Title:** | |  |  |  |
| **Credentialing Contact/Title:** | |  |  |  |
| **Provider Relations Contact/Title:** | |  |  |  |
| **Compliance Officer:** | |  |  |  |
| **Privacy Officer:** | |  |  |  |
| **Case Management Contact/Title:** | |  |  |  |
| **HEALTH PLAN CONTRACTS/ENROLLMENT** | | | | |
| **IPA Total Enrollment in all participating health plans:** | | | | |
| **IPA total enrollment for each of the following:** | | | | |
| **Commercial:** | **MediCare:** | | **MediCal:** | |
| **IPA Enrollment for (** insert health plan) **for each of the following**: | | | | |
| **Commercial:** | **MediCare:** | | **MediCal:** | |
| **CONTRACTED PHYSICIANS** | | | | |
|  | | | | |