|  |  |
| --- | --- |
| **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:**  |
|  |  |

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| --- | --- | --- | --- |
| **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** |
|  |