External Reporting Form
Quality of Care/Quality of Service Concern

Member ID# _____
Date of Birth _____
Member Name _____
Line of Business _____
Date _____
Provider ID# _____
Referral by _____
Referral Contact # _____
Date of event _____

Summary of Event

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Please complete this form and send to the Safety Concern Fax at:

1-855-297-1705

Confidential, Do Not Duplicate