Potential Quality Issue (PQI) Referral Form

Do not photocopy this form. The information contained is confidential and peer-review protected. Complete all fields and forward to Blue Shield of California ("Blue Shield") through secure email to externalpqi@blueshieldca.com **or by fax to (818) 228-5114.**

Purpose

The Potential Quality Issue (PQI) Referral Form is intended to be used to report potential or suspected deviations from the standard of care that require further review to determine justification.

Confidentiality, security and accurate submission

- Blue Shield uses the confidential PQI Referral Form to support the assessment and improvement of care provided to Blue Shield health plan members.
- All PQI forms are handled securely and reviewed confidentially.
- Refer issues identified as member appeals or member grievances to Blue Shield's Appeals and Grievances Department for appropriate case handling and resolution.

To maintain confidentiality and the legally privileged nature of this PQI referral, please adhere to all of the following guidelines:

1. Do not discuss the details of this referral form content with anyone other than those with whom you have been specifically directed to communicate.
2. Do not use this form for any associate disciplinary actions.
3. Do not make or retain photocopies of this form content under any circumstances.
4. **Do not** document within the patient's medical record that a referral form has been submitted; rather, objectively report pertinent information of the incident within the patient's medical record, whenever appropriate.

Referral content

1. All of the fields on the PQI form are **required** fields.
2. **All sections** of the PQI referral form must be completed.
3. Complete and submit this referral/report directly to Blue Shield through secure email to externalpqi@blueshieldca.com or by fax to (818) 228-5114 within one business day of the event/occurrence. The case will be forwarded for clinical evaluation and/or review.
4. Incomplete referral forms are returned to the associate who initiated referral, by either email or fax, depending on how the referral was received.

Referral source

Date of referral:	Contact phone number:	Contact fax number:
Referred by (first and last name):	Incident/occurrence identified by:	

Member information

Member last name:	**Member MI:**	Member first name:	Member subscriber ID:
Name of current primary care physician:		**Current participating physician group:**	

Potential quality issue event dates

Date(s) of event:	Admission date:	Prior Admission dates (if applicable)

Details regarding the provider and/or group against which the filing is submitted

Provider/practitioner name:	Associated provider/practitioner physician group:
Provider/practitioner location (street, city, state, ZIP code):	Provider/Practitioner national provider identifier (NPI):

Description of event: Please provide a complete and detailed summary. This information must be typed, not handwritten.

Based on my judgment, I believe there was a deviation in the standard of care resulting in a potential quality of care issue for reasons described below.