United Healthcare | MARCH® Vision Care

Potential Quality Issue Referral Form

Identifying Data

Member name: ________________________________ DOB: _______________ Member ID #: _________________

Provider name: ____ NPI #: _____________________________

Provider address: ____ Phone #: ___________________________

Group/plan: _________________________ Phone #: ________________________ PR #: _______________________

Referred by: __________________________ ICD-10 code: ________________________ Client case: Y or N

Reason for Quality Management Department review (check ALL that apply)

- ☐ There was a **delay in diagnosis or medical treatment**
- ☐ There was a **diagnosis error**
- ☐ There was a **treatment error**
- ☐ There was an **unexpected trauma or other safety issues during health care visit**
- ☐ There was a **lack of required medical record documentation**
- ☐ There was a **complaint about accessibility to care**
- ☐ There was a **complaint about a delay in obtaining an appointment or services**
- ☐ There was a **potential quality of care issue**
- ☐ There was a **quality of service issue**
- ☐ Other - please specify:

Brief summary of events (include date of service. Attach additional pages, as needed.)

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Referring staff signature: ____

Department: _______________________ Date: _______________ Phone #: _________________________

Submit this completed form and any additional documentation (i.e., copy of complaint/grievance) to the Quality Management Department by fax 855-640-6735. To maintain confidentiality of this referral, please do not copy completed form.

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