PROVIDER CONCERN

CONCERN SUBMITTED BY:

DATE:

TCM NAME:

FACILITY NAME/ADDRESS:

PROVIDER NAME:

CLAIMANT NAME:

CLAIM NUMBER:

EMPLOYER:

INSURANCE COMPANY:

SPECIFIC CONCERN/QUESTIONS TO ADDRESS:

NOTED PROVIDER PATTERNS (EXAMPLES: OUTSIDE OF MDG OR ODG, MID-LEVEL TX ONLY):

TCM RECOMMENDATION FOR ACTION PLAN/CORRECTION/EDUCATION:

RESEARCH:

RESOLUTION: