Inland Empire Health Plan
2018 IPA Delegation Oversight Audit Tool
Biographical Information

Date of Review:	**Surveyor:**	
Name of IPA:		**ID. #**
Address:		
City/State		
Phone:		**FAX:**
Name of Management Company (if applicable)		
Address:		
City/State:		
Phone:		**FAX:**

IPA Contact Personnel	**Phone**	**FAX**	**E-Mail**
Executive Director:			
Medical Director:			
QM Chairperson:			
QM Contact/Title:			
UM Chairperson:			
UM Contact/Title:			
CM Contact/Title:			
Credentialing Contact/Title:			
Provider Relations Contact/Title:			
Compliance Contact/Title:			
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		
Total Number:	**Total number of PCP's:**	**Total number of specialist:**
Total number of OB's:	**Total number of Pediatricians:**	
Have you included the following in your total:		
OB/GYN's: yes no	**Pediatricians: yes no**	

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Capitated Specialist: (number/specialty)	
UM Criteria used by IPA:	**Copyright Date:**