

Data Compliance Quality Improvement Plan

Use of this form is required. ** When you are done, please fax to our office at: 651-644-9853. Thank you! **

If you need additional space, please feel free to attach other pages. Questions? Please call Tom at: 651-644-9877

Submitted by (Facility Name) _____

Affiliation _____

(If any, such as: DaVita, FMC, etc)

CMS Facility Provider # (6 digits) _____

Goal Achieve => 90% Combined Compliance Rate on CMS Data Compliance Reports _____

Problem Statement _____

Root Cause(s) _____

Actions necessary to correct problem(s) _____

Evaluation—How will progress be measured? _____

Dates of measurement _____

Person(s) Responsible _____

Date Initiated _____

Date Submitted to Network 11 _____

Name of Administrator

Signature of Administrator