Potential Quality Issue Form

Please complete this form if you have a concern regarding the quality of health care performed by a TRICARE West Region provider. The submission will go directly to the West Region Clinical Quality Department for review within one business day. Please be assured we take all concerns seriously and will thoroughly investigate the matter and take all appropriate actions. Due to federal or state privacy regulations, we are unable to share any details, results or actions as a result of the investigation as it pertains to a clinical quality program.

Beneficiary Information

Last Name: First Name:

Last four digits of SSN: Date of Birth (MM/DD/YYYY):

Phone (XXX-XXX-XXXX): Email Address:

Requester Information

☐ Please check the box if the person filling out this form is the beneficiary and leave the section below blank.

Last Name: First Name:

Phone (XXX-XXX-XXXX): Email Address:

Relationship to the Beneficiary:

Quality of Health Care Concern Information

Health Care Provider or Facility Name:

Date of Incident (MM/DD/YYYY):

Select Quality Issue Type:
☐ Potential Quality Issue ☐ Potential Safety Issue

Date of Service Start (MM/DD/YYYY) *if applicable*:

Date of Service End (MM/DD/YYYY) *if applicable*:

Additional Details

Please describe incident or concern(s).

Send completed form and supporting documentation via fax to 866-852-1931 or mail to:
TriWest Healthcare Alliance
P.O. Box 2688, Virginia Beach, VA 23450
Attention: TRICARE Clinical Operations – CQM #48200

The Information collected with this form is subject to the Privacy Act of 1974 (5 U.S.C. 552A, as amended) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information shall be considered for official use only and protected accordingly. Any individual responsible for unauthorized disclosure or misuse of this information may be subject to a fine of up to $50,000 and/or other sanctions as appropriate.