



Inland Empire Health Plan
2019 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: