Transforming Lives

Trillium HEALTH RESOURCES

Plan of Correction

Provider Name: _____ **Phone:** _____

Provider Contact for follow-up: _____ **Fax:** _____

Trillium Provider

Email: _____

Address: _____ Provider NPI# **Date:**

Finding (State the Problem)	Corrective Action Steps (How will this problem be corrected?)	What systems changes will be made to ensure this situation and others like it do not occur again?	Responsible Party	Time Line
				Implementation Date:
				Projected Completion Date:

TRILLIUM USE ONLY:

☐ Accepted ☐ Not Accepted Date _____ Initials _____ Revision Due _____

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