

PPC/HCAC submission form

After reporting to the Department of Health Care Services (DHCS) using the DHCS secure online [reporting portal](#), all delegated and non-delegated groups should use this form to notify Blue Shield of California Promise Health Plan about provider preventable conditions (PPCs) or health care acquired conditions (HCAC).

INSTRUCTIONS

Complete the form below and attach it, along with the member’s medical records, to an email. Please ensure the email is sent following your organization’s secure email method policy and encrypt any emails sent to Blue Shield Promise that contain patient/member protected health information. Send the email to BSPromisePPCHCAC@blueshieldca.com.

A) Facility where PPC occurred

NPI:	
Billing NPI:	
Facility name:	
Street Address:	
City, State and ZIP code:	

B) PPC type (Please check one)

OPPC – Other Provider-Preventable Condition in any healthcare setting

HCAC – Health Care Acquired Condition in an acute inpatient setting

C) PPC dates

Date Occurred:	
Date Admitted:	

D) Patient Information

CIN:	
Birth Date:	
Name (First, Middle, Last):	
Street Address:	
City, State and ZIP code:	
Is the member enrolled in a Medi-Cal managed care plan?	Yes No (Fee for Service)
Do you intend to submit a claim?	Yes No Unknown

E) Person submitting report

Name:	
Title:	
Phone Number:	
Email Address:	