Provider Corrective Action Plan (CAP) Template

Complete only the fields that apply. Keep responses brief, factual, and tied directly to the finding. Attach evidence for completed actions or upon request.

1. Provider / Review Information

Provider Legal Name		**Date Submitted** *(MM/DD/YYYY)*	
Tax ID #		**NPI** *(if applicable)*	
13-digit PROMISe Provider Number		**Service Location Address**	
Provider Contact *(Name, Title)*		**Email / Phone**	
Final Findings / Notice Date *(MM/DD/YYYY)*		**CAP Due Date** *(MM/DD/YYYY)*	

2. Findings and Required Compliance

Finding(s): *(e.g. State the finding exactly as identified in the final findings letter or notice)*

Requirement(s)/Regulation(s) cited: *(List the regulation, MA policy, agreement requirement, or citation identified in the letter)*

Immediate correction, if already completed: *(Briefly note any claim correction, repayment/recoupment, documentation update, or other action already completed.)*

3. Root Cause

Use short, plain language. Explain what caused the issue and when/how it occurred.
Avoid long process narratives unless needed to explain the root cause.

Root Cause / Deficiency *(What caused the error/noncompliance?)*	Operational Process or People Involved *(Which process, policy, system, role, or handoff was involved?)*	Evidence Reviewed *(Records, reports, claims, logs, policy, training records, etc.)*

4. Corrective Action Plan

Each action should identify what will change, who owns it, the target date, and how PHW/provider will confirm the action worked.

Deficiency / Issue	Corrective Action *(Specific action to fully address the deficiency)*	Owner *(Name/title)*	Target Date / Status	Monitoring / Proof *(Report, log, audit, claim record, policy update, roster, etc.)*

5. Effectiveness Check

How will you know the CAP worked? *(Describe the metric, report, audit, or review that will show the deficiency was corrected or reduced.)*

Follow-up timing: *(Example: 30/60/90-day audit, monthly review for 3 months, or other appropriate cadence.)*

Adjustment process: *(Describe how corrective actions will be updated if monitoring shows the issue continues.)*

6. Supporting Documentation

☑ *Note: Please check all boxes that apply for supporting documentation you are attaching.*

- ☐ **Final findings letter / notice**
- ☐ **Claim review, correction, repayment, or recoupment documentation, if applicable**
- ☐ **Policy/procedure update, if applicable**
- ☐ **Training materials, roster, or staff attestations, if applicable**
- ☐ **Monitoring report, audit worksheet, log, or management review evidence**
- ☐ **Other supporting records (describe):** _____

7. Attestation / Signature

[Enter Provider Agency Name]: _____ attests that the corrective actions listed above will be implemented, monitored, and supported by documentation available upon request.

Authorized Representative:

Title	Signature	Date

Email your completed Corrective Action Plan PDF to: **CorrectiveAction@PAHealthWellness.com**