



**Compliance Review Services, Inc.**

Consulting & Training Services

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Established 1997

**PLAN OF CORRECTION / EVIDENCE OF COMPLIANCE / 10 DAY CLARIFICATION ORDER FORM**

Current contract? Y \_\_\_\_\_ N \_\_\_\_\_ Outstanding Balance with CRS? Y \_\_\_\_\_ N \_\_\_\_\_

Date agency received deficiencies: \_\_\_\_\_ Plan of Correction due date: \_\_\_\_\_

Company Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Completed POC to be emailed to: \_\_\_\_\_ @ \_\_\_\_\_

Agency Tel #: \_\_\_\_\_ Agency Fax #: \_\_\_\_\_

ACCREDITATION USER ID: \_\_\_\_\_ PASSWORD: \_\_\_\_\_

Name of Program	Check Item	Cost for Program	Total Amt. Due
Medicaid Program POC		\$1000.00	
Accreditation for Healthcare Organizations TJC CHAP		\$1000.00	
10 Day Clarification TJC/ CHAP/ACHC		\$1000.00	
Department of Health and Human Services (DHHS) Plan of Correction for State and Medicare		\$1000.00	
RUSH JOB FEE: 3 business days notice or less to complete POC/EOC		Add \$250.00 for all RUSH jobs	
<b>Total Amount Due:</b>			\$

**CREDIT CARD PAYMENT INFORMATION**

**Covid19 update**

**PLEASE USE OUR PAYMENT ONLINE PORTAL [www.compliancereviewservices.com](http://www.compliancereviewservices.com) "Make a Payment"**

VISA: \_\_\_\_\_ MASTER CARD: \_\_\_\_\_ AMEX: \_\_\_\_\_ DISCOVER: \_\_\_\_\_ (check card type)

CARD NUMBER: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_ V Code \_\_\_\_\_

CREDIT CARD BILLING ADDRESS AND ZIP CODE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

CRS CEO INIT: \_\_\_\_\_ DATE: \_\_\_\_\_