Date Issue Identified (MM/DD/YY) (Completed By The CMS Team Lead)	Brief Description Of Issue (Completed By The CMS Team Lead)	Condition Language (Completed By The CMS Team Lead)	Related to Pre-Audit Issue Summary? (Completed By The CMS Team Lead) (Y/N)	Pre-Audit Issue Summary Number (Completed By The CMS Team Lead) (If applicable)	Detailed Description of the Issue (Explain what happened) (This and remaining fields to be completed by Sponsor)	Root Cause Analysis for the Issue (Explain why it happened)	Methodology - Describe the process that was undertaken to determine the # of members impacted	# of Members Impacted	Actions Taken to Resolve System/Operational Issues	Date System/Operational Remediation Initiated (MM/DD/YY)	Date System/Operational Remediation Completed (MM/DD/YY)	Actions Taken to Resolve Negatively Impacted Beneficiaries Including Outreach Descriptions and Status	Date Beneficiary Outreach and Remediation Initiated (MM/DD/YY)	Date Beneficiary Outreach and Remediation Completed (MM/DD/YY)

Cardholder ID	Contract ID	Plan ID	Effective date of contract (MM/DD/YY) (MM/DD/YY)	MTM Program eligibility determination date (MM/DD/YY) (MM/DD if not determined eligible)	MTM Program enrollment date (MM/DD/YY) (N/A if not applicable)	Combining MTM Program number (N/A)	Beneficiary identified as cognitively impaired? (Y/N)	Date identified as cognitively impaired? (MM/DD/YY) (N/A if not applicable)	Beneficiary identified as long term care resident at the time CMR offered or administered? (Y/N)	MTM Program opt out date (MM/DD/YY) (N/A if not applicable)	MTM Program opt out reason (N/A if not applicable)	MTM Program opt out method (Phone/Fax/Mail/Email/Text/Other) (N/A if not applicable)	Date CMR offered (MM/DD/YY) (N/A if not applicable, NONE if no CMR offered for member enrolled in MTM program)	CMR delivery method (N/A if not applicable)	Date CMR declined (MM/DD/YY) (N/A if not applicable)	Method CMR declined (Phone/Fax/Mail/Email/Text/Other) (N/A if not applicable)	Provider (prov) administering CMR (N/A if not applicable)	Date CMR written summary provided (MM/DD/YY) (N/A if not applicable, NONE if no summary provided)	TMR date (MM/DD/YY) (N/A if not applicable, NONE if no TMR performed)	Date TMR interventionist performed (MM/DD/YY) (N/A if not applicable)	<Other requested data>	<Other requested data>	<Other requested data>