ELECTRONIC HEALTH RECORDS (EHR) DEMONSTRATION APPLICATION TO PARTICIPATE

The goal of the Electronic Health Records Demonstration (EHR) is to establish a 5-year pay-for-performance demonstration project with small and medium sized primary care physician practices to promote the adoption and use of certified EHRs to improve the quality of patient care for chronically ill Medicare patients. Doctors who meet or exceed performance standards established by CMS will receive incentive payments for managing the care of eligible Medicare beneficiaries. Practices incorporating greater use of health information technology into their office practices will be eligible to earn additional incentives.

Each practice applying to participate must have a designated staff person authorized to speak for the group, provide requested information, and to whom all correspondence will be directed. All physicians who are members of the practice and who wish to participate in the demonstration must sign the enclosed data sharing consent form agreeing to share data submitted to CMS and/or its contractors assisting in the implementation or evaluation of the demonstration.

Those who wish to participate should fill out this form completely. Completing this form does not guarantee participation in the demonstration. CMS reserves the right to limit the number of practices that may participate.

Physician Office Information

For office use only

Name of Practice

1. How many physicians are part of this practice?_____
Of these how many primarily provide primary care *(general practice, family practice, gerontology, internal medicine)*? _____

2. Briefly describe your practice in terms of how it is organized, locations, services offered, affiliation with larger networks, etc. _____

_____

_____

_____

3. Address of primary practice location

Street Address			Office Number
City	State	Zip	Country

4. List all other locations that are part of this practice and participating in the demonstration

Location #2 Name of Practice at this location			Office Number
Street Address			
City	State	Zip	Country
Location #3 Name of Practice at this location			Office Number
Street Address			
City	State	Zip	Country

❑ Check here if additional locations. Attach information on additional pages

5. Designated Contact Person

Name of Designated Contact Person	Title

Street Mailing Address *(if different from primary practice location)*

City	State	Zip	Country

Telephone	E-mail

6. Secondary Contact Person (if applicable, for mailing purposes)

Name of Secondary Contact Person	Title

Street Mailing Address *(if different from primary practice location)*

City	State	Zip	Country

Telephone	E-mail

7. Estimated number of Medicare Fee-For-Service patients that use your practice as primary source of care _____

8. All incentive payments associated with the demonstration will be made to the practice and not to individual physicians. Please provide information regarding the legal entity to which payments should be made, as specified below.

Name of entity to which payments should be made

Street Mailing Address *(if different from primary practice location)*	Practice Tax Identification Number

City	State	Zip	Country

9. Do you have an electronic health record (EHR) in your office?
Yes ❑ (Please respond to questions that follow, **and then proceed to Question #11**)

If yes, what is the vendor and product? _____

Is this system certified by the Certification Commission for Health Information Technology (CCHIT)?
Yes ❑ No ❑ Unknown ❑

What is the date of certification?
2006 ❑ 2007 ❑ 2008 ❑ Unknown ❑ Other ❑ _____

No ❑ (Please go to Question #10)

10. If you do not currently have an EHR, when do you plan to implement an EHR?
0–6 months? ❑ 7–12 months? ❑ 13–24 months? ❑ Other? ❑ _____

Has an EHR product been selected?
Yes ❑ No ❑

If yes, what is the vendor and product? _____

Is this system certified by the Certification Commission for Health Information Technology (CCHIT)?
Yes ❑ No ❑ Unknown ❑

What is the date of certification?
2006 ❑ 2007 ❑ 2008 ❑ Unknown ❑ Other ❑ _____

11. If you have an electronic system in your office, please describe the type of health information technology **currently used** in your practice, either as part of an EHR or independently as a stand-alone product *(check all that apply)*:

❑ Electronic patient visit notes
❑ Electronic patient-specific problem lists
❑ Automated patient-specific alerts and reminders
❑ Electronic disease-specific patient registries
❑ Clinical decision support/automated references to best practices
❑ Patient e-mail
❑ Patient-specific educational materials
❑ On-line referrals to other providers
❑ Clinical messaging with other physicians
❑ Transmission of records to hospitals or other facilities

Laboratory tests:
❑ On-line order entry
❑ On-line results viewing

Radiology tests:
❑ On-line order entry
❑ On-line results (reports and/or digital films)

E-Prescribing:
❑ Printing and/or faxing Rx
❑ On-line Rx transmission to pharmacy

Other: _____ _____

PHYSICIANS PARTICIPATING IN THE EHR DEMONSTRATION IN THIS PRACTICE

Practice Name

Practice Group PIN number *(if applicable)*	Group NPI *(if applicable)*

Please provide information listed in the chart below for all physicians in this practice applying to participate in this demonstration.

Physician Name (PRINT)	Specialty	Tax Identification Number*	Medicare Provider Identification Number (PIN) at this Location	Individual NPI–National Provider Identification number	Consent Form Attached (Y/N)

* Provide the Tax Identification Number used by each physician when billing for Medicare services **as a member of this practice**.

CONSENT TO SHARE DATA

As an applicant to the Electronic Health Records Demonstration project, I agree to comply with the requirements of this demonstration, including sharing all data submitted to CMS and/or its contractors assisting in the implementation or evaluation of the demonstration.*

Provider Name *(print)*	
Provider Signature	Date
Medicare Provider Identification Number	Individual National Provider Identifier (NPI)

Provider Name *(print)*	
Provider Signature	Date
Medicare Provider Identification Number	Individual National Provider Identifier (NPI)

Provider Name *(print)*	
Provider Signature	Date
Medicare Provider Identification Number	Individual National Provider Identifier (NPI)

Provider Name *(print)*	
Provider Signature	Date
Medicare Provider Identification Number	Individual National Provider Identifier (NPI)

* **This form must be signed by each participating physician in the practice. If additional signatures are necessary, please copy and submit additional signature sheets.**