DEPARTMENT OF HEALTH AND HUMAN SERVICES

CROWNWeb
Consolidated Renal Operations in a Web Enabled Network

Form Approved
OMB No. 0000-0000

CROWNWeb Batch Data Submission Authorization Form

Page 1 of this form must be completed to establish a delegation of authority for a Corporate Entity or Vendor to submit data on behalf of a Dialysis Facility to CMS. All Fields marked with an asterisk (*) are required.

*** Type of Request:**	☐ **Create Delegation of Authority**	☐ **Revoke Delegation of Authority**
*** Date of Request:** (mm/dd/yyyy)		

(A) Dialysis Facility Information

*** Facility Name:**		
*** Corporate/Vendor Affiliation:**	*** Phone Number:** ( )	**Fax Number:** ( )
*** Business Address 1:**	*** City:**	*** State:**
Business Address 2:	*** Zip Code 1:**	**Zip Code 2:**
Facility Contact Name:	*** Facility Administrator Name:**	
Facility Contact Phone: ( )	*** Facility Administrator Phone: ( )**	
Facility Contact Email Address:	*** Facility Administrator Email Address:**	

(B) Corporate Entity or Vendor Information

*** Organization Name:**	**Corporate Entity or Vendor Number:** (CMS Use Only)	
*** Business Address 1:**	*** City:**	*** State:**
Business Address 2:	*** Zip Code 1:**	**Zip Code 2:**
*** Organization Contact Name:**	*** Phone Number:** ( )	**Fax Number:** ( )
*** Organization Contact Email Address:**		

(C) Authorization for Facility-Collected Data Submission into CROWNWeb

The Dialysis Facility specified in (A) authorizes the Corporate Entity/Vendor specified in (B) to transmit data, view data, and/or update data according to the following chart:

(1) Transmit CROWNWeb data and receive validation errors and information	☐ **Patient data**	*☐ **Allow**	☐ **Do Not Allow**	*** Effective Date:**
	☐ **Facility data**	*☐ **Allow**	☐ **Do Not Allow**	(mm/dd/yyyy)
(2) Allow viewing of CROWNWeb data	☐ **Patient data**	*☐ **Allow**	☐ **Do Not Allow**	*** Effective Date:**
	☐ **Facility data**	*☐ **Allow**	☐ **Do Not Allow**	(mm/dd/yyyy)
(3) Allow updating of CROWNWeb data	☐ **Patient data**	*☐ **Allow**	☐ **Do Not Allow**	*** Effective Date:**
	☐ **Facility data**	*☐ **Allow**	☐ **Do Not Allow**	(mm/dd/yyyy)

The corporate entity/vendor (1) agrees to transmit data for all payers via CROWNWeb in the agreed-upon data format provided by CMS (XML format), and (2) certifies that all of its data collection and transmission activities are in accordance with all HIPAA regulatory requirements regarding security and privacy. This authorization shall remain in effect until the Facility Administrator informs CMS of changes through the ESRD Network Organization with facility jurisdiction or through the CROWNWeb Helpdesk (see below).

*** Authorized by Facility Administrator:** (Printed Name)	*** Facility Administrator Signature:** (Must be original signature)
*** CMS Medicare Provider Number (CMS Certification Number or CMS National Provider Identifier):**	*** Date Signed:** (mm/dd/yyyy)

Mail completed form to:
Centers for Medicare and Medicaid Services, Mailstop S3-02-01 -- OCSQ CROWNWeb Helpdesk,
7500 Security Boulevard, Baltimore, Maryland 21244-1850

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PRIVACY ACT STATEMENT

The information on page 1 of this form is collected and maintained under the authority of Title 5 U.S. Code, Section 552a(e)(10) (The Privacy Act of 1974). This information is used for assigning, controlling, tracking, and reporting authorized access to and use of CMS's computerized information and resources. The Privacy Act prohibits disclosure of information from records protected by the statute, except in limited circumstances.

The information you furnish on page 1 of this form will be maintained by CMS in the CROWNWeb Authentication Service (CAS) application and the original form will be maintained by the QualityNet Helpdesk, 1-866-288-8912 (qnetsupport@ifmc.sdps.org). The data may be disclosed as a routine use disclosure under the routine uses established for this system as published at 59 FED.REG.41329 (08-11-94) and as CMS may establish in the future by publication in the Federal Register.

Furnishing the information on this form is voluntary. However, if you do not provide this information, you may not be granted access to CMS computer systems.

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0000-0000. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:
The Centers for Medicare and Medicaid Services, Attention: PRA Reports Clearance Officer, Mailstop C4-26-05, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.