

## Quality Reporting Program Reconsideration Request Form

When CMS determines that a facility did not meet the Quality Reporting Program requirement(s), the facility may submit a request for reconsideration to CMS, by the deadline identified on the Annual Payment Update Notification letter.

### \* Indicates required fields

### Facility Contact Information

\*Program Requesting Reconsideration: Inpatient \_\_\_ Outpatient \_\_\_ Inpatient Psych \_\_\_ PPS-exempt Cancer \_\_\_ ASC \_\_\_

\*Date of Request (MM/DD/YYYY): \_\_\_/\_\_\_/\_\_\_

\*CMS Certification Number (CCN): \_\_\_\_\_

\*Facility Name: \_\_\_\_\_

**Provide the facility's CEO contact information.** This will be used for official correspondence. Please ensure within your organization that U.S. Mail and deliveries from overnight services that are directed to this address will reach the necessary party(ies).

\*CEO Last Name: \_\_\_\_\_

\*CEO First Name: \_\_\_\_\_

\*CEO E-Mail Address: \_\_\_\_\_

\*CEO Address Line 1: (must include physical street address): \_\_\_\_\_

\_\_\_\_\_  
CEO Address Line 2: \_\_\_\_\_

\_\_\_\_\_  
\*CEO City: \_\_\_\_\_

\*CEO State: \_\_\_ \*CEO Zip Code: \_\_\_\_\_ - \_\_\_\_\_

\*CEO Telephone Number: \_\_\_ - \_\_\_ - \_\_\_ ext. \_\_\_\_\_

Additional Contact Last Name: \_\_\_\_\_

Additional Contact First Name: \_\_\_\_\_

Additional Contact E-Mail Address: \_\_\_\_\_

Additional Contact Address Line 1: (must include physical street address): \_\_\_\_\_

\_\_\_\_\_  
Additional Contact Address Line 2: \_\_\_\_\_

\_\_\_\_\_  
Additional Contact City: \_\_\_\_\_

Additional Contact State: \_\_\_ Additional Contact Zip Code: \_\_\_\_\_ - \_\_\_\_\_

Additional Contact Telephone Number: \_\_\_ - \_\_\_ - \_\_\_ ext. \_\_\_\_\_

### Reconsideration Request Information

**Quality Reporting Program  
Reconsideration Request Form**

**\*Reason Facility Failed to Meet the Annual Payment Update Requirements:** These details were provided in the formal CMS notification letter that was sent to your CEO by the Centers for Medicare & Medicaid Services (CMS).

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**\*Reason for Reconsideration Request:** Please state your reason for requesting reconsideration. You must identify the specific reason(s) for believing your facility did meet the Quality Reporting Program requirement(s) and should receive the full annual payment update.

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\*Was your reason for not meeting the annual requirement(s) related to Validation? Yes \_\_\_ No \_\_\_

**PLEASE NOTE:** Requests related to validation element mismatches for the clinical process measures require additional facility **actions as follows:**

- Complete the Validation Review for Reconsideration Request.
  - o Provide written justification for each data element you wish to appeal and mail a copy of the entire medical record (as previously sent to the Clinical Data Abstraction Center (CDAC) contractor) for the appealed element(s).
  - o Medical records must be received by the deadline identified on the Annual Payment Update Notification letter.

Additional information can be found at [QualityNet.org](http://QualityNet.org)

**Quality Reporting Program  
Reconsideration Request Form**

**Additional Comments:**

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PRA Disclosure 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 collection is 0938-XXXX . The time required to complete this information collection is estimated to average 10 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: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.