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

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 Contact Information

*Last Name ____ *First Name ____

*Address (must include physical street address) ____

*City ____ *State ____ *ZIP Code ____

*Telephone Number ____ Ext. ____ *E-Mail Address ____

Additional Contact Information

Last Name ____ First Name ____

Address (must include physical street address) ____

City ____ State ____ ZIP Code ____

Telephone Number ____ Ext. ____ E-Mail Address ____

Reconsideration Request Information

***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 and Medicaid Services (CMS).

*__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.

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

IF APPLICABLE, 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.

- Provide a 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).
- Medical records must be received by the deadline identified on the Annual Payment Update Notification letter.

Additional comments:

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 XXXX-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 21244-1650.

Additional information can be found at QualityNet.org