Quality Reporting Program

Extraordinary Circumstance/Disaster Extension or Waiver Request Form (Paper Submission)

A facility can request an extension or waiver of various Quality Reporting Program requirements due to extraordinary circumstances beyond the control of the facility. To request an extension or waiver, complete and submit this form within 30 days of the disaster or extraordinary circumstance.

ALL sections must be complete and specific in order for Centers for Medicare and Medicaid Services to consider the request.

*Indicates required fields

Facility Contact Information

*Program Requesting Waiver:

O Inpatient O Outpatient O Inpatient Psych O PPS-Exempt Cancer O ASC

*Date of Request

*Date of Extraordinary Circumstance/Disaster

*CMS Certification Number (CCN)

*Facility Name

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

Disaster Waiver Request Information

*Submission quarter(s) affected (Please state "None" if not applicable.)

*Validation quarter(s) affected (Please state "None" if not applicable.)

*Date facility will re-start data submission

*Justification for the submission re-start date:

*Reason(s) for requesting an extension or waiver - Please include the specific requirement or data that should be waived. (Attach additional documentation when necessary to include details.)

*Please provide evidence of the impact of the disaster or extraordinary event including (but not limited to) photographs, Web links, newspaper and other media articles. Attach supporting documentation when necessary.

Additional comments:

Disaster Waiver Request Form Submission

In the event the facility is unable to submit the form electronically, it can be submitted by fax or mailed to their QIO or CMS designee.

Complete and submit the Notice of Participation Agreement form using one of the following options:

- via My QualityNet to the Global Exchange Group "PPS Exempt Cancer Hosp. QR Support ";
- via secure FAX to Program Manager Telligen PCHQR Support (515)-558-5073, or
- via mail to:

Telligen PCHQR Support
1776 West Lakes Parkway,
West Des Moines, IA 50266
Attn. Program Manager

DO NOT SEND THE COMPLETED FORM VIA E-MAIL.
Following receipt of the request form, an e-mail acknowledgement will be sent confirming the form has been received.

PRA Disclosure Statement