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 __ Psych __ Cancer __ ASC __

* Date of Request (MM/DD/YYY): ____/____/____

* 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 Email 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 Email 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. _____

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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 & 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.

_____

_____

_____

_____

Additional information can be found at QualityNet.org

Additional Comments:

_____

_____

_____

_____

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Please send completed forms to the Inpatient Psychiatric Support Contractor:

- Via *My QualityNet* to the Global Exchange Group “Inpatient Psych QR Support Contractor”,
- Via secure FAX to Jane Tehel, Program Manager Telligen IPFQR Support (515)-558-5073, or
- Via mail to:

  Telligen IPFQR Support
  1776 West Lakes Parkway
  West Des Moines, IA 50266

  Attn. Jane Tehel, Program Manager

DO NOT SEND THE COMPLETED FORM VIA EMAIL.

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 0938-1171. 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, and 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.