

Attachment D: Registration Form

CAHPS Health Plan Survey Registration Request Form

Complete the information below. The CAHPS Database will review your request and will send you an e-mail with the information to access the 2013 CAHPS Health Plan Survey Data Submission System.

*** Required Item**

*Organization Name:

*First Name:

*Last Name:

Title/Position:

*Address 1 (No P.O. Box allowed):

Address 2: (No P.O. Box allowed):

*City:

*State:

*Zip Code:

*Telephone number: () - Ext.

Fax number: () -

*Email address:

***Identify your role as a participant**

Sponsor (Organization that receives the sponsor report)

Coalition

Vendor

Please list the name(s) of the sponsor organization you are representing:

Health Plan but not a Sponsor (Submitting data for a sponsor and does not receive a report)

As a Health Plan are you submitting data on behalf of:

Sponsor Organization
Please list the name of the sponsor(s):

Coalition
Please list the name of the coalition(s):

Other Organization
Please list the name of the other organization(s):

Additional Information about your role as a participant:

***Are you the primary contact?**

Yes

No

***Has your organization previously participated in the CAHPS Health Plan Survey?**

Yes

No

***Do you submit data to NCQA?**

Yes

No