

Centers for Medicare & Medicaid Services (CMS) Quality Reporting Program Extraordinary Circumstances Extensions/Exemptions Request Form

A facility can request an extension of or exemption from various Quality Reporting requirements due to extraordinary circumstances beyond the control of the facility. To request an extension or exemption, complete and submit this form. Hospital Inpatient, Inpatient Psychiatric, and PPS-Exempt Cancer Hospitals must be submitted **within 30 days of the extraordinary circumstance**. Hospital Value-Based Purchasing, Hospital-Acquired Condition Reduction, and Hospital Readmissions Reduction must be submitted **within 90 days of the extraordinary circumstance**. Ambulatory Surgical Center and Hospital Outpatient must be submitted **within 45 days of the extraordinary circumstance**.

All sections must be complete and specific in order for the CMS to consider the request.

***Indicates required fields**

***Facility Contact Information**

***Program Requesting Extension/Exemption**

<input type="checkbox"/> Hospital Inpatient	<input type="checkbox"/> Inpatient Psychiatric	<input type="checkbox"/> PPS-Exempt Cancer Hospitals	<input type="checkbox"/> Hospital Value-Based Purchasing
<input type="checkbox"/> Hospital-Acquired Condition Reduction	<input type="checkbox"/> Hospital Readmissions Reduction	<input type="checkbox"/> Hospital Outpatient	<input type="checkbox"/> Ambulatory Surgical Centers

*Date of Request _____ *Date of Extraordinary Circumstance _____

*Facility Name _____

*CMS Certification Number (CCN) _____

*National Provider Identifier Number (NPI) (ASC only) _____ (Place additional NPIs in Additional Comments section.)

CEO/Designee 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 _____

Extraordinary Circumstances Extension/Exemption Request Form

Extension or Exemption 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 restart data submission _____

***Provide justification for the submission restart date.**

***Enter reason for requesting an extension or exemption. Please include the specific requirements or data that should be extended or exempted. Attach supporting documentation when necessary.**

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

Additional Comments (Attach additional documentation/comments if necessary):

*Signature: _____

*Date: _____

Extraordinary Circumstances Extension/Exemption Request Form Submission Instructions

Complete and submit this form via the *QualityNet Secure Portal*, Secure File Transfer "WAIVER EXCEPTION WITHHOLDING" group. If unable to submit via Secure File Transfer, please submit via e-mail to QRSupport@hcgis.org, secure fax to 877-789-4443, or mail to 3000 Bayport Drive, Suite 300, Tampa, FL 33607. The Support Contractor will forward, as directed, to CMS.

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 **0938-1022**. 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 estimates(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, MD 21244-1650.