Quality Reporting Program
Reconsideration Request Form

When the Centers for Medicare & Medicaid Services (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

*Date of Request

*Facility Name

*CMS Certification Number (CCN) Or NPI (10 digits)

* Place additional NPIs in Additional Comments section.

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 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, including:
  - A written justification for each data element you wish to appeal.
  - Do ***not*** include any other documentation in the submission for reconsideration. Submit only the Reconsideration Form.
  - Medical records will be directly obtained from the CDAC.

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 www.qualitynet.org.