Inpatient Psychiatric Facility Quality Reporting Program

Vendor Authorization Form

All fields are required.

Provider Name_____ CCN_____

Address_____ Telephone_____

Select One:

[ ] Add New Vendor Authorization [ ] Edit Vendor Authorization

Vendor Name_____ Vendor ID_____

Address_____ Telephone_____

Contact Name_____ FAX _____

Enter dates for which this vendor is authorized to submit data on your behalf. Enter "End" dates only if you intend to discontinue authorization for this vendor for those dates. Otherwise, leave "End" dates blank. Carefully review the information you have entered to verify the new vendor data.

This Vendor is authorized for the following Measures set(s):

Measure Set	Discharge Start Date	Discharge End Date	Data Transmission Start Date	Data Transmission End Date
IPF				

(Hospital Name)_____ authorizes (Vendor)_____ to enter/transmit data for the specified dates. The vendor agrees to enter/transmit data for all payers via *QualityNet*. The data collected has also met the CMS standard protocols and transmission requirements. The vendor ensures that all of its data collection and transmission activities are in accordance with HIPAA regulatory requirements regarding security and privacy. The authorization remains in effect for the specified vendor until dates are entered to end the authorization.

Please confirm your changes to this vendor's authorization. CMS requires that you confirm the changes you have made to the vendor authorization to submit data on your facility's behalf. Please indicate your confirmation by signing below.

On behalf of my facility, I approve this vendor to transmit our facility quality of care data.

Hospital Representative Name	Hospital Representative Signature	Date

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IPFs should complete the form in a fillable PDF format and submit via email to: IPFQualityReporting@hcqis.org.

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, 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 21244-1850. Expiration Date: xx/xx/xxxx