Facility Medicare Provider Number:					Email Address:			All fields are required. Column L indicated missing/invalid data.			
Record #	Patient's Medicare (HIC Number of NA)	Patient's Date of Birth (MM/DD/YYYY)	Date of Procedure (MM/DD/YYYY)	Patient Symptomatic (Y/N)	Patient Meets High Surgical Risk Criteria (Y/N)	Modified Rankin Scale Score if Patient Experienced Stroke Pre-Procedure (0 to 6 of NA)	Percent (%) Stenosis by Angiography (0 to 99)	Percent (%) Stenosis of Second Lesion (0 to 99 or NA)	Embolic Protection Used (Y/N)	Complications During Hospitalization (y/N)	Missing or Invalid Data in Column(s):
1											
2											
3											
4											
Etc.											