Hospital Inpatient Quality Reporting (IQR) Program Validation Educational Review Form

Hospitals complete this form to request educational review of their validation results when discrepancies are found. Complete the information below from the Case Detail Report (fields marked with an asterisk are required) and upload this form to the Value Incentives and Quality Reporting Center (VIQRC) Validation Support Contractor via the *QualityNet Secure Portal* to the **Validation Contractor** group. For additional details, please see the Educational Review Process document on the Inpatient Data Validation Educational Reviews page of QualityNet.

Hospital Provider CCN*: _____

Hospital Name*: _____

Hospital State*: _____

Validation Qtr. & Yr. (Example - 3Q15)*: _____

Hospital Contact Name*: _____

E-mail Address*: _____

Telephone*: _____

Date Submitted*: _____

Abstraction Control Number (ACN)*: _____

NHSN Event ID: _____ **(if HAI Measure question)**

Patient ID*: _____

Admit Date*: _____

Discharge Date*:_____

Measure Set*: _____

Element Name*:_____

Rationale* (Please document your rationale for each review requested in the space below. Supplemental information that was not located in the original Medical Record sent to the CMS Clinical Data Abstraction Center (CDAC) cannot be accepted, as the results of each of the reviews will be non-comparable.)

Abstraction Control Number (ACN): _____

NHSN Event ID: _____ (if HAI Measure question)

Patient ID: _____

Admit Date: _____

Discharge Date: _____

Measure Set: _____

Element Name: _____

Rationale (Please document your rationale for each review requested in the space below. Supplemental information that was not located in the original Medical Record sent to the CMS Clinical Data Abstraction Center (CDAC) cannot be accepted, as the results of each of the reviews will be non-comparable.)

Abstraction Control Number (ACN): _____

NHSN Event ID: _____ (if HAI Measure question)

Patient ID: _____

Admit Date: _____

Discharge Date: _____

Measure Set: _____

Element Name: _____

Rationale (Please document your rationale for each review requested in the space below. Supplemental information that was not located in the original Medical Record sent to the CMS Clinical Data Abstraction Center (CDAC) cannot be accepted, as the results of each of the reviews will be non-comparable.)