I acknowledge that, to the best of my ability, all of the information reported for this hospital for the PPS-exempt Cancer Hospital Quality Reporting (PCHQR) Program, as required for the annual Fiscal Year 2020 PCHQR Program requirements, is accurate and complete.  This information includes the following:

* Measure sets as defined for the PCHQR Program
* Current Notice of Participation and QualityNet Security Administrator.

I understand this acknowledgement covers all PCHQR information reported by this hospital (and any data or survey vendor(s) acting as agents on behalf of this hospital) to the Centers for Medicare & Medicaid Services (CMS) and its contractors for the FY 2020.

To the best of my knowledge, this information was collected in accordance with all applicable requirements.  I understand that this information is used as the basis for the public reporting of quality of care and patient assessment of care.

I understand that this acknowledgement is required for purposes of meeting any Fiscal Year 2020 PCHQR Program requirements.

[ ] Yes, I Acknowledge

CCN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complete and submit the Data Accuracy and Completeness Acknowledgement Form** via email to: PCHQualityReporting@hcqis.org.

Following receipt of the form, an email acknowledgement will be sent confirming the form has been received.

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