**CCN Hospital Name**

**Instructions: For each measure, (1)** Please enter the Total Initial Patient Population and indicate the total Medicare and Non-Medicare populations. **(2)** Provide the Sample size information. ***Note:*** *When not sampled, provide only Total Initial Patient Population – Not Sampled.*

**NQF 1822 External Beam Radiotherapy Measure**

Sample Frequency: Not Sampled

| Not Sampled Patient Population | Number |
| --- | --- |
| **Total Initial Patient Population** |  |
| **Medicare Initial Patient Population** |  |
| **Non-Medicare Initial Patient Population** |  |

**Sample Frequency:** **Quarterly**

Initial Inpatient Population

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Initial Inpatient Population | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Total |
| Medicare |  |  |  |  |  |
| Non-Medicare |  |  |  |  |  |
| Total |  |  |  |  |  |

Sample Size

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sample Size | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Total |
| Medicare |  |  |  |  |  |
| Non-Medicare |  |  |  |  |  |
| Total |  |  |  |  |  |

Please refer to specifications on the QualityNet web site:   
<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772864228>

Complete and submit EBRT Measure Paper-Based Form via email to: [PCHQualityReporting@hcqis.org](mailto:PCHQualityReporting@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 0938-1175 and expires XX/XX/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 21244-1850. \*\*\*\*\*CMS Disclaimer\*\*\*\*\*Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact James Poyer at (410) 786-2261.