MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670

STATEWIDE APPLICATION

Reclassification Period: Federal Fiscal Years 2018 – 2020

Please read the MGCRB rules before completing this application.

This application must be completed and received by the MGCRB by **September 1, 2016**. Failure to comply will result in dismissal.

This application must also be sent to CMS via e-mail at wageindex@cms.hhs.gov. Delivery to CMS does not constitute delivery to the MGCRB.

General Information

Statewide Information

State: _____

Representative Information

Identify the representative contact for all communications regarding the application:

Name: _____

Organization: _____

Address: _____

_____

City, State, Zip: _____

E-mail Address: _____

Telephone Number: _____

Listing of Providers

Under a tab labeled "Providers," the statewide representative must provide a listing of all participating acute care inpatient prospective payment system ("IPPS") hospitals in the state. The listing is to be submitted in the following format:

Column A	Column B	Column C	Column D
Provider Number	Provider Name	Provider Address	Did provider also file an individual or group application? (Y/N)

All IPPS hospitals in the state must agree to the reclassification to a statewide wage index through a signed affidavit. **Under a tab labeled "Affidavits," attach an affidavit for each participating provider in accordance with 43 C.F.R. § 412.235.**

Under a tab labeled "Representative" or "Rep," attach a letter of representation for each participating provider in accordance with Board Rule 2.4.

Note: The Board will rule on a statewide request first and then a group reclassification request before it reviews any individual reclassification request. If the Board approves the statewide application, it will dismiss any group or individual reclassification applications filed by participating providers.

Background Questionnaire

Note: All required documentation as noted by the questions below must be annotated with the applicable question number and included **under a tab labeled "Background."**

1. Are all the acute care inpatient prospective payment system ("IPPS") providers in the state listed as members of the statewide application?

   ☐ Yes ☐ No

   Attach support that identifies all the IPPS providers in the state.

   If no, attach an explanation that identifies which provider(s) are excluded and the basis for the exclusion.

2. Are the providers in the statewide application requesting an oral hearing?

   ☐ Yes ☐ No

   If yes, attach a letter of rationale for the oral hearing request.

Certification Statements

☐ *I certify that the application is filed in full compliance with the statutes, regulations, and Board rules.

☐ *I understand that an omission, misstatement, or error made in the statewide application and supporting information may be grounds for denial of the statewide application.

☐ *I certify that I am authorized to file an application on behalf of the listed statewide group.

Signature: _____

Representative Name: _____

Organization: _____

Date: _____