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

INDIVIDUAL 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

Provider Organization Information

Provider Number: _____

Provider Name: _____

Representative Information

Identify the representative contact for all communications regarding the application:

Name: _____

Organization: _____

Address: _____

_____

City, State, Zip: _____

E-mail Address: _____

Telephone Number: _____

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

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. Is the provider also a member of a group reclassification request?

   ☐ Yes ☐ No

2. Is the provider also a member of a statewide wage index area request?

   ☐ Yes ☐ No

   Note: The Board will rule on a statewide request first and then a group reclassification request before it reviews any individual reclassification request.

3. Is the provider an urban hospital currently classified as rural by the CMS Regional Office under 42 C.F.R. § 412.103?

   ☐ Yes ☐ No ☐ Status Pending

4. Is the provider currently classified as a sole community hospital ("SCH")?

   ☐ Yes ☐ No

5. Has the provider lost its designation as an SCH due to previous MGCRB reclassification?

   ☐ Yes ☐ No

   If yes, attach the letter from the Medicare Administrative Contractor ("MAC") or CMS Regional Office indicating the date and reason the provider's SCH status was lost.

6. Is the provider currently a rural referral center ("RRC")?

   ☐ Yes ☐ No

Background Questionnaire
(continued)

7. Has the provider ever been an RRC?

☐ Yes ☐ No

If yes, attach the letter from the MAC or CMS Regional Office indicating the RRC status.

8. Has the provider lost its designation as an RRC due to previous MGCRB reclassification?

☐ Yes ☐ No

If yes, attach the letter from the MAC or CMS Regional Office indicating the date and reason that the provider's RRC status was lost.

9. Is the provider the single acute care inpatient prospective payment system (“IPPS”) hospital in the provider's urban area?

☐ Yes ☐ No

If yes, attach documentation to support the provider’s status as the single acute care IPPS hospital.

10. Is the provider classified as a Lugar hospital and deemed to an urban area under 42 C.F.R. § 412.64(b)(3)(i)?

☐ Yes ☐ No

11. Is the provider requesting an oral hearing?

☐ Yes ☐ No

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

Expires 7/31/2020

Reclassification Request

Provider's Current Area

Identify the geographic address for the front entrance of the provider:

Street Address: _____

City: _____

County: _____

State: _____

Zip Code: _____

Identify the CBSA applicable to the provider's physical location:

CBSA Code: _____

CBSA Name: _____

Reclassification Requests

How many MGCRB reclassification requests are included in this application? ____

For each request, **under tabs marked by priority order**, attach a separate reclassification request form to identify the:

- priority of request, (e.g., primary, secondary, tertiary, etc.);
- CBSA of requested area;
- reclassification method, e.g.,
    - Proximity (Distance),
    - Proximity (Employee Commuting Pattern),
    - Special Access (Distance), or
    - Special Access (Driving Time);
- required supporting documentation including, but not limited to, maps and wage comparisons.

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 provider's application and supporting information may be grounds for denial of the provider's application.

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

Signature: _____

Representative Name: _____

Organization: _____

Date: _____