



CMS Quality Reporting 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 Data Validation Educational Reviews pages of *QualityNet*.

Hospital Provider CCN*: _____

Hospital Contact Name*: _____

Hospital Name*: _____

E-mail Address*: _____

Hospital State*: _____

Telephone*: _____

Validation Qtr. & Yr. (Example - 3Q 2017)*: _____

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: _____

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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.)

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 **0938-1022** (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 Disclosure**** 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 the Validation Support Contractor at validation@hcqis.org.