

MEDICARE/MEDICAID PSYCHIATRIC HOSPITAL SURVEY DATA (CMS-724)

SECTION I: To be completed by the hospital

Name of Hospital B1	Street Address B2	City or County B3	State B4	ZIP Code B5
Hospital Provider Number B6	Total Number of Beds B7	Total Number of Certified Beds B8	Other Data — Does the hospital operate a forensic unit? Yes No B9	

For the past year: A. Total number of admissions to certified areas from (month) _____ (year) _____ B10	B. Age Range of Patients B11
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C. Medicare/Medicaid Billings	D. Other Data — Does the hospital operate a separate MEDICAID ONLY-Residential Treatment Program for Psychiatric patients under the age of 22? Yes No B12
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	Billed	Collected
MEDICARE/Part A		
MEDICARE/Part B		
MEDICAID		

13. Current Hospital Statistics (on days of survey) [certified beds only]

Name of Ward	Bed Capacity	Patient Census
		Total Patient Census B13

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SECTION II: To be completed by the survey team

Dates of Survey (beginning) ____/____/____ (mm) (day) (year) B14	Dates of Survey (ending date) ____/____/____ (mm) (day) (year) B15	Type of Survey: Initial (B16) Complaint (B19)	Recertification (B17) Second Follow-up (B20)	Follow-up (B18) Concurrent with General Hospital (B21)
Survey Team Composition Administrator (B22) Nurse (B23) Dietician (B24) Pharmacist (B25) Social Worker (B26) LSC Specialist (B27) Sanitarian (B28) Physician (B29) Psychologist (B30) Other _____ (B31)		Total Number of Surveyors on Site SA (B32) RO (B33) Consultant (B34) CO (B35) Total Number of Surveyors on Site _____ (B36)		

19. Certification of Findings

I certify that I have reviewed each Condition of Participation and Related Standards for Psychiatric Hospitals, and unless indicated on the CMS-2567, the Facility was found to be in compliance with the Conditions and/or Standards.

Signature	Title	Date
Signature	Title	Date
Signature	Title	Date
Signature	Title	Date
Signature	Title	Date

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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 **0938-0378 (Expires XX/XX/202X)**. The time required to complete this information collection is estimated to average **30 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 any 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, C4-26-05, Baltimore, Maryland 21244-1850.

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