

SUPPLEMENTAL TO FORM CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-XXXX
EXPIRES XX-XX-XXXX

PAYMENT ADJUSTMENTS FOR DOMESTIC NIOSH-APPROVED SURGICAL N95 RESPIRATORS

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

PART I - DOMESTIC NIOSH-APPROVED SURGICAL N95 RESPIRATORS PAYMENT ADJUSTMENT ELIGIBILITY AND DATA

		DOMESTIC RESPIRATORS RESPIRATORS	NON-DOMESTIC RESPIRATORS RESPIRATORS	
		1	2	
1	Did the hospital or hospital healthcare complex purchase domestic (column 1) or non-domestic (column 2) respirators? Enter "Y" for yes or "N" for no in each column. If "Y" for either column, complete line 2.			1

		DOMESTIC RESPIRATORS		NON-DOMESTIC RESPIRATORS		
		TOTAL COST	NUMBER PURCHASED	TOTAL COST	NUMBER PURCHASED	
		1	2	3	4	
2	Enter the total cost of domestic respirators purchased in column 1 and the number of domestic respirators purchased in column 2. Enter the total cost of non-domestic respirators purchased in column 3 and the number of non-domestic respirators purchased in column 4.					2

PART II - CALCULATION OF COST DIFFERENTIAL FOR DOMESTIC NIOSH-APPROVED SURGICAL N95 RESPIRATORS

		DOMESTIC RESPIRATORS	NON-DOMESTIC RESPIRATORS	COST DIFFERENTIAL	
		1	2	3	
1	Total cost of NIOSH-approved surgical N95 respirators purchased				1
2	Number of NIOSH-approved surgical N95 respirators purchased				2
3	Average cost per respirator				3
4	Hospital-specific unit cost differential for domestic respirators				4
5	Total cost differential for domestic respirators				5

PART III - CALCULATION OF PAYMENT ADJUSTMENT FOR DOMESTIC NIOSH-APPROVED SURGICAL N95 RESPIRATORS

	CCN _____		CCN	CCN	TOTAL	
	HOSPITAL PART A	HOSPITAL PART B	IPF SUBPROVIDER PART B	IRF SUBPROVIDER PART B		
	1	2	3	4		
1	Medicare costs					1
2	Total facility costs					2
3	Medicare percentage					3
4	Domestic NIOSH-approved surgical N95 respirators payment adjustment					4

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 for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to be .50 hours 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 Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. 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 1-800-MEDICARE.