Ambulatory Surgical Center Quality Reporting (ASCQR) Withdrawal of Participation Form

*This form is to be used only to **withdraw** from the Ambulatory Surgical Center Quality Reporting (ASCQR) Program. To withdraw from the ASCQR Program, the completed form must be submitted (either emailed or faxed) to the ASCQR Program Support Contractor.*

By withdrawing from the ASCQR Program, an ASC may be subject to a reduction of 2.0 percentage points in its Medicare payment update for the applicable calendar year and going forward. Withdrawal from the ASCQR Program removes the ASC from having data publicly reported. For detailed program requirements, see the ASCQR Program Reference Checklist on the QualityNet.cms.gov website.

The facility or facilities specified by National Provider Identifier (NPI) is/are withdrawing from ASCQR Program participation at and in effect as of the date specified below; if no date is specified, the date of receipt will be assigned. Based on this withdrawal, it is understood that the specified facility or facilities will not be listed as a participant/participants on the QualityNet website, and data submitted for the specified payment years will not be made publicly available. This withdrawal remains in effect until participation is reinstated as specified by the ASCQR Program. ASCs may withdraw individual NPIs under a CMS Certification Number (CCN); it is not mandatory that all NPIs under a CCN be withdrawn under a withdrawal request.

Confirmation:

☐ **I hereby issue withdrawal from the ASCQR Program for the facility specified below.**
Note: If signing for additional facilities to withdraw, please use the following page to list those facilities individually. Additional pages may be added if necessary.

Payment Year for Withdrawal: _____

Facility Name:_____

CCN:_____

NPI: _____

City, State, ZIP Code: _____

Phone Number: _____

Facility/Health System CEO (or designee):

Name (please print): _____

Title:_____

Date:_____Signature:_____

Fax or Email Form to:
Secure Fax: 877.789.4443
Email: QRFormsSubmission@hsag.com

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CCN:______________________________
NPI: ______________________________
City, State, ZIP Code: ______________________________
Phone Number: ______________________________

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