Centers for Medicare & Medicaid Services (CMS)
Hospital Quality Reporting (HQR) Data Validation Educational Review Request 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 and upload this form to the **Validation Support Contractor** group via the CMS **Managed File Transfer (MFT)** application at https://qnetmft.cms.gov/. For additional details on how to upload, please see the Educational Review Process document on the respective inpatient or outpatient Data Validation Educational Reviews pages of the CMS *QualityNet* website at https://qualitynet.cms.gov.

**Fields marked with an asterisk are required.*

Inpatient or Outpatient*: _____

Validation Qtr. & Yr. (Example - 3Q 2020)*: _____

Hospital Provider ID/CCN*: _____ **Hospital State*:** _____

Hospital Name*: _____

Hospital Contact Name*: _____

E-mail Address*: _____

Telephone*: _____

Date Submitted*: _____

Abstraction Control Number (ACN)*: _____

Patient ID*: _____

Admit Date*: _____ (if inpatient question)

Discharge Date*: _____ (if inpatient question)

Encounter Date*: _____ (if outpatient question)

NHSN Event ID*: _____ (if HAI Measure question)

Measure Set*: _____

Element Name*: _____

Rationale*: (Please document the rationale for each review requested for each case below. Provide any supporting page numbers, form names, symptoms, etc. from the medical record *originally* submitted to Clinical Data Abstraction Center (CDAC), including any questions or reasons for disputing the rationale; being as detailed as possible. If the rationale is blank, the form will be returned for it to be completed. Supplemental information that was not located in the original medical record sent to the CDAC cannot be accepted, as the results of each of the reviews will be non-comparable.)

If submitting more than one question, you may use the pages below. If submitting more than five questions, another form may be submitted.

Abstraction Control Number (ACN)*: _____ **Patient ID*: _____**

Admit Date*: _____ (if inpatient question) **Discharge Date*: _____** (if inpatient question)

Encounter Date*: _____ (if outpatient question) **NHSN Event ID*: _____** (if HAI Measure question)

Measure Set*: _____ **Element Name*: _____**

Rationale*:

Abstraction Control Number (ACN)*: _____ **Patient ID*: _____**

Admit Date*: _____ (if inpatient question) **Discharge Date*: _____** (if inpatient question)

Encounter Date*: _____ (if outpatient question) **NHSN Event ID*: _____** (if HAI Measure question)

Measure Set*: _____ **Element Name*: _____**

Rationale*:

Abstraction Control Number (ACN)*: _____ **Patient ID*: _____**

Admit Date*: _____ (if inpatient question) **Discharge Date*: _____** (if inpatient question)

Encounter Date*: _____ (if outpatient question) **NHSN Event ID*: _____** (if HAI Measure question)

Measure Set*: _____ **Element Name*: _____**

Rationale*:

Abstraction Control Number (ACN)*: _____ **Patient ID*: _____**

Admit Date*: _____ (if inpatient question) **Discharge Date*: _____** (if inpatient question)

Encounter Date*: _____ (if outpatient question) **NHSN Event ID*: _____** (if HAI Measure question)

Measure Set*: _____ **Element Name*: _____**

Rationale*: