Hospital Value-Based Purchasing (VBP) Program
Independent CMS Review Request Form

The Centers for Medicare & Medicaid Services (CMS) has implemented an independent CMS review that is an additional appeal process available to eligible hospitals participating in the Hospital Value-Based Purchasing (VBP) Program, beyond the existing Review and Corrections process and Appeal process. Hospitals dissatisfied with the outcome of an Appeal may request an Independent CMS Review. Hospitals are strongly encouraged to request the independent CMS review **within 30 days** after they receive a decision on their Appeal. Hospitals can anticipate a review decision within 90 calendar days following receipt of the Independent CMS Review Request.

Note: Hospitals must receive a determination from CMS of their Appeal Request prior to requesting an independent CMS review request for the applicable fiscal year.

Fields marked with an asterisk (*) are required.

*Review and Corrections and Appeal Information:

*Date of Independent CMS Review Request (MM/DD/YYYY): _____

*Date of Appeal Request (MM/DD/YYYY): _____

*Date of Appeal Decision from CMS (MM/DD/YYYY): _____

*Date of Review and Corrections Request (MM/DD/YYYY): _____

*Date of Review and Corrections Decision from CMS (MM/DD/YYYY): _____

*Hospital Information:

*CMS Certification Number (CCN): _____

*Hospital Name: _____

*CEO Contact Information:

*CEO Name: _____

*CEO Email Address: _____

*CEO Address:
(Must include physical street address) _____

*City: _____

*State: _____ *ZIP Code: _____

*CEO Telephone Number: _____ Extension _____

Hospital Value-Based Purchasing (VBP) Program
Independent CMS Review Request Form

*Hospital Security Official Contact Information:

*Name: _____

*Email Address: _____

*Address:
(Must include physical street address)

*City: _____

*State: _____ *ZIP Code: _____

*Telephone Number: _____ Extension _____

*Basis for Requesting Independent CMS Review:

*Describe the specific reasons for the basis of your request for an Independent Review. Provide all related supporting documents.

_____ Supporting documents attached (indicate Yes/No)

Submit this completed form via the *Hospital Quality Reporting Secure Portal*, Managed File Transfer to QRFormsSubmission@hsag.com, via email to QRFormsSubmission@hsag.com, or via secure fax to 877-789-4443.

Following receipt of the Independent CMS Review Request Form, CMS will send an email acknowledgement confirming the form has been received. Once a determination has been made, CMS will provide a formal decision of the outcome of the Independent Review.