Hospital Value-Based Purchasing (VBP) Program

Review and Corrections Request Form

Hospitals may review and request correction of their hospitals' performance scores on each condition, domain, and Total Performance Score (TPS). Hospitals must submit the Review and Corrections Request within **30 calendar days** of the availability to download the Percentage Payment Summary Report on *Hospital Quality Reporting* (the date this report is available for download is Day 1). **Note:** Hospitals can request an appeal only after first requesting a Review and Corrections of their performance scores. Hospitals that do not submit this Reviews and Corrections request within 30 calendar days of Percentage Payment Summary Report announcement waive eligibility to later submit a CMS Hospital VBP Appeal Request for the applicable fiscal year.

Fields marked with an asterisk (*) are required.

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

***Hospital Information:**

*CMS Certification Number (CCN): _____

*Hospital Name: _____

***Hospital CEO Contact Information:**

*First and Last Name: _____

*Email Address: _____

*Address (Physical street address): _____

*City: _____

*State: _____ *ZIP Code: _____

*Telephone Number: _____ Extension: _____

***Hospital Security Official Contact Information:**

*First and Last Name: _____

*Email Address: _____

*Address (Physical street address): _____

*City: _____

*State: _____ *ZIP Code: _____

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*Telephone Number: _____ Extension: _____

***Corrections – Select All That Apply (Minimum of one reason is required):**

_____ Condition-Specific Score (CSS)

_____ Provide the disputed condition score

_____ Provide the proposed condition score

_____ Domain-Specific Score (DSS)

_____ Provide the disputed domain score

_____ Provide the proposed domain score

_____ Total Performance Score (TPS)

_____ Provide the disputed total performance score

_____ Provide the proposed total performance score

***Reasons**:
Please provide all evidence supporting your hospital's claim that the CSS, DSS, and/or TPS are incorrect. Describe the specific details for the reason of your review and request for correction of the items selected above.

_____ **Supporting documents attached (indicate Yes/No)**

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

Following receipt of the Review and Corrections Form, an email acknowledgement will be sent confirming the form has been received. Once a determination has been made, a decision of the outcome of the review will be provided.

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 the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor at (844) 472-4477.