Form Approved: OMB # 0938-1390 Expiration 12/31/2025



HHS Compliance Review Program Triage Questionnaire Providers

Section 1. Organization and Point of Contact Information

Organization Inform	<u>nation</u>					
Organization			Doing			
Name:			Business	As:		
Is your organization c	urrently going t	hrough liquidation	ı? ☐ Yes ☐	No		
If yes, please describe	e the phase.					
Contact Name:			Title:			
Telephone:			E-mail:			
Business Address:			City:			
State/Province:		Country:			Zip):
Point of Contact Inf						
☐ Check if same as a	bove					
Organization						
Name:						
Contact Name:			Title:			
Telephone:			E-mail:			
Business			City:			
Address:						
State/Province:		Country:			Zip:	
ection 2. Type of C		L				
Check All That Appl	ly					
☐ Large Provider¹		☐ Business As	ssociate			
☐ Small Provider ²						

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. The valid OMB control number for this information collection is 0938-1390 from the year of 2024 through 2025. The objective of the HIPAA Administrative Simplification information collection program is to conduct assessments and identify whether a covered entity is compliant with the HIPAA - adopted standards, and administrative simplification. The time required to complete this information collection is estimated to average less than **10 hours** per response (4 forms x 60 minutes/form), including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory (under 45 CFR § 160.310) 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 Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

¹ Provider with more 25 or more full-time employees, or a physician, practitioner, facility, or supplier with 10 or more full-time equivalent employees

² Provider with less than 25 full time employees, or a physician, practitioner, facility, or supplier with less than 10 full time equivalent employees



<u>Providers - Required HIPAA Covered Transactions:</u>

For each transaction listed below, select the appropriate check box, and provide additional details as requested. A response is expected for each transaction type.

Eligibility Inquiry for a Health Plan		
5010, 270 Health Care Eligibility Verification Reque	est	
Does your organization construct and/or transmit this transaction electronically to a trading partner?	☐ Yes ☐ No ☐ N/A	
If YES: By what means?	☐ Real Time ☐ Batch	
If NO : Has your organization ever been asked to provide this transaction electronically?		
In the space below, please provide an explanation as to why your organization does not construct and/or transmit this transaction to a trading partner.	☐ Yes ☐ No	
If N/A: In the space below, please provide an explanation as to why	•	
required to construct and or transmit this transaction to a trading pa	artner.	
Does another company or entity construct and/or transmit this transaction on behalf of your organization?	☐ Yes ☐ No	
If Yes: Please provide the company or entity name:		



Health Care Claim Status	
5010, 276 Health Care Claim Status Request	
Does your organization construct and/or transmit this transaction electronically to a trading partner?	☐ Yes ☐ No ☐ N/A
If YES: By what means?	☐ Real Time ☐ Batch
If NO: Has your organization ever been asked to provide this transaction electronically? In the space below, please provide an explanation as to why your organization does not construct and/or transmit this transaction to a trading partner.	☐ Yes ☐ No
If N/A: In the space below, please provide an explanation as to why required to construct and or transmit this transaction to a trading page	•
Does another company or entity construct and/or transmit this transaction on behalf of your organization?	☐ Yes ☐ No
If Yes: Please provide the company or entity name:	



Referral Certification and Authorization	
5010, 278 Health Care Services Review Request	
Does your organization construct and/or transmit this transaction electronically to a trading partner?	☐ Yes ☐ No ☐ N/A
If YES: By what means?	☐ Real Time ☐ Batch
If NO: Has your organization ever been asked to provide this transaction electronically? In the space below, please provide an explanation as to why your organization does not construct and/or transmit this transaction to a trading partner.	☐ Yes ☐ No
If N/A: In the space below, please provide an explanation as to why	•
required to construct and or transmit this transaction to a trading pa	ntner.
Does another company or entity construct and/or transmit this transaction on behalf of your organization?	☐ Yes ☐ No
If Yes: Please provide the company or entity name:	



Health Care Claims or Equivalent Encounter Information		
5010, 837 Health Care Claim - Institutional		
Does your organization construct and/or transmit claims		
electronically to any trading partner?		
Or	☐ Yes ☐ No ☐ N/A	
Does your organization transfer encounter information		
electronically?		
If NO : Has your organization ever been asked to provide this		
transaction electronically?		
In the control below where a consider on control by the control by	☐ Yes ☐ No	
In the space below, please provide an explanation as to why your		
organization does not construct and/or transmit this transaction		
to a trading partner.		
If N/A: In the space below, please provide an explanation as to why	your organization is not	
required to construct and or transmit this transaction to a trading pa	· · · · · · · · · · · · · · · · · · ·	
required to construct and or transmit this transaction to a trading pe	ai tilei.	
Does another company or entity construct and/or transmit this		
transaction on behalf of your organization?	☐ Yes ☐ No	
If Yes: Please provide the company or entity name:		



Health Care Claims or Equivalent Encounter Information		
5010, 837 Health Care Claim - Professional		
Does your organization construct and/or transmit claims		
electronically to any trading partner?		
Or Does your organization transfer encounter information	☐ Yes ☐ No ☐ N/A	
electronically?		
If NO : Has your organization ever been asked to provide this		
transaction electronically?		
In the space below, please provide an explanation as to why your	☐ Yes ☐ No	
organization does not construct and/or transmit this transaction		
to a trading partner.		
If N/A: In the space below, please provide an explanation as to why	vour organization is not	
required to construct and or transmit this transaction to a trading partner.		
Does another company or entity construct and/or transmit this transaction on behalf of your organization?	☐ Yes ☐ No	
If Yes: Please provide the company or entity name:		



Health Care Claims or Equivalent Encounter Information		
5010, 837 Health Care Claim - Dental		
Does your organization construct and/or transmit claims electronically to any trading partner? Or Does your organization transfer encounter information electronically?	☐ Yes ☐ No ☐ N/A	
If NO : Has your organization ever been asked to provide this transaction electronically? In the space below, please provide an explanation as to why your	☐ Yes ☐ No	
organization does not construct and/or transmit this transaction to a trading partner.		
If N/A: In the space below, please provide an explanation as to why required to construct and or transmit this transaction to a trading page	· ·	
Does another company or entity construct and/or transmit this transaction on behalf of your organization?	☐ Yes ☐ No	
If Yes: Please provide the company or entity name:		



Health Care Claims or Equivalent Encounter Information		
NCPDP D.0 Pharmacy Claim		
Does your organization construct and/or transmit claims electronically to any trading partner? Or Does your organization transfer encounter information	☐ Yes ☐ No ☐ N/A	
electronically?		
If NO : Has your organization ever been asked to provide this transaction electronically?		
In the space below, please provide an explanation as to why your organization does not construct and/or transmit this transaction to a trading partner.	☐ Yes ☐ No	
If N/A: In the space below, please provide an explanation as to why required to construct and or transmit this transaction to a trading page 1.	-	
Does another company or entity construct and/or transmit this transaction on behalf of your organization?	☐ Yes ☐ No	
If Yes: Please provide the company or entity name:		