



## 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 Unified File Management(UFT)/**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\*:** \_\_\_\_\_

**Hospital Contact Name\*:** \_\_\_\_\_

**Validation Qtr. & Yr. (Example - 3Q 2025)\*:** \_\_\_\_\_

**E-mail Address\*:** \_\_\_\_\_

**Hospital Provider ID/CCN\*:** \_\_\_\_\_ **Hospital State\*:** \_\_\_\_\_

**Telephone\*:** \_\_\_\_\_

**Hospital Name\*:** \_\_\_\_\_

**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\*:**

**PRA Disclosure Statement** 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 **0938-1022 (Expires xx/xx/xxxx)**. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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. **\*\*\*\*CMS Disclosure\*\*\*\* Please do not send applications, claims, payments, medical records, or any 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 Validation Support Contractor at validation@telligen.com.**