

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 *QualityNet* Security Administrator/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.

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