

Centers for Medicare & Medicaid Services Data Standard Change Request Form	Date of Request
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After completing this form, e-mail the request to DataAdmin@cms.hhs.gov.

SECTION I – DATA ANALYST INFORMATION

Data Analyst Name				Date Required (mm/dd/yyyy)
Project Title (if applicable)	Project Number	Project Manager	Bus Sponsor	Division/Branch/Section/Unit

SECTION II – STANDARD TOPIC INFORMATION

TOPIC	(Check one) <input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Remove	
	Topic Number	Topic Title
	Topic Category: <input type="checkbox"/> Enterprise Data Topic <input type="checkbox"/> Logical Data Topic <input type="checkbox"/> Physical Data Topic <input type="checkbox"/> Other	
REQUESTED CHANGE		
CHANGE JUSTIFICATION		

SECTION III – DATA ARCHITECT / OVERSIGHT MANAGER APPROVAL: By digitally signing this Form, I hereby approve the standard change as described above and authorize its appropriate use for data management and development.

DA Manager (First and Last Name)	Date Completed (mm/dd/yyyy)
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