

Centers for Medicare & Medicaid Services				Date of Request
Standard Term Request Form				
After completing this form, e-mail the request to DataAdmin@cms.hhs.gov				
Central/Local DA Name				Date Required (mm/dd/yyyy)
Project Name (if applicable)	Project Acronym	Project Owner	Business Owner	Component/Group/Division
TERM	(Check one) <input type="checkbox"/> New <input type="checkbox"/> Change			
	Proposed TERM		Proposed TERM Abbreviation <input type="checkbox"/> Acronym?	
	TERM Role: <input type="checkbox"/> Object Class Term <input type="checkbox"/> Qualifier Term <input type="checkbox"/> Property Term <input type="checkbox"/> Representation Class Term			
TERM DEFINITION				
EXAMPLE OF TERM USAGE				
DATA ANALYST JUSTIFICATION				
Glossary Administrator (First and Last Name)			Date Completed (mm/dd/yyyy)	