REQUEST FOR SURVEY OF §489.20 AND §489.24 ESSENTIALS OF PROVIDER AGREEMENTS:

Responsibilities of Medicare Participating Hospitals and Critical Access Hospitals (CAH) in Emergency Cases

1. Name and Address of State Agency	2. Name and Address of Hospital or CAH
3. CMS Certification Number	4. Complaint Intake Number

DO NOT INFORM THE HOSPITAL OR CAH IN ADVANCE OF THE SURVEY

5. Type of Emergency Alleged *(check all that apply)*

☐ Labor ☐ Other OB ☐ Medical ☐ Trauma ☐ Psychiatric ☐ Surgical ☐ Other

6. Source of Complaint *(check all that apply)*

- ☐ Patient
- ☐ Family
- ☐ Friend
- ☐ Entity Self-Reported
- ☐ Current Staff
- ☐ Former Staff
- ☐ Physician
- ☐ Coroner
- ☐ State Survey Agency
- ☐ Other State Agency
- ☐ CMS – Regional Office
- ☐ CMS – Central Office
- ☐ Medicare Administrative Contractor
- ☐ Other Federal Agency
- ☐ Quality Improvement Organization
- ☐ Accrediting Organization
- ☐ Transferring Hospital
- ☐ Receiving Hospital
- ☐ Ombudsman
- ☐ Congressional Inquiry
- ☐ Media
- ☐ Anonymous
- ☐ Other

7. Nature of Allegation *(check all that apply)*

489.20

- ☐ Policies/Procedures
- ☐ Receiving Hospital Reporting
- ☐ Signage
- ☐ Maintenance of Records
- ☐ Physician On-Call List
- ☐ Central Log

489.24

- ☐ Medical Screening Examination
- ☐ Stabilizing Treatment
- ☐ Delay in Examination or Treatment
- ☐ Appropriate Transfer
- ☐ Whistleblower
- ☐ Recipient Hospital Responsibilities

A copy of the allegation is enclosed. The name of the complainant must not be disclosed to the provider.

Due to the serious nature of this complaint, please complete the onsite investigation within 5 working days of this RO authorization.

Signature of Survey/Certification Branch Manager/Designee	Region	Date