



**2017 ELIGIBLE PROFESSIONAL (EP)
PAYMENT ADJUSTMENT RECONSIDERATION APPLICATION
FOR THE MEDICARE ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM**

Complete this application if you received a letter from CMS stating that you are subject to the 2017 Medicare EHR payment adjustment and feel that this payment adjustment is in error.

The submission deadline for the 2017 Medicare EHR Incentive Program payment adjustment reconsideration application is February 28, 2017.

SECTION 1: PRACTICE INFORMATION

Provide the group practice information below and complete Section 3 for all EPs applying for this payment adjustment reconsideration. A maximum of 25 EPs may apply on one reconsideration application.

Practice Name*		
Total Number of EPs filing under this application	Organizational/Group NPI (10 digits) All EPs listed in Section 3 must be part of the same group	
Practice Address Line 1 (Street Name and Number – <u>Not</u> a Post Office Box or Practice Name)*		
Practice Address Line 2 (Suite, Room, etc.)		
City/Town*	State (2 character code)*	Zip Code (5 digits)*
Contact Name (person completing reconsideration):		
Email Address* (This is how we will communicate with you.)		
Business Telephone Number (Include Area code)	Extension	



**SECTION 2: PAYMENT ADJUSTMENT RECONSIDERATION
FOR THE MEDICARE EHR INCENTIVE PROGRAM**

Have the EPs previously demonstrated meaningful use?

Yes – The EPs previously demonstrated meaningful use

Indicate in which program year(s) below:

- 2015
- 2014
- 2013
- 2012
- 2011

No – The EPs have not previously demonstrated meaningful use

INDICATE THE TYPE OF RECONSIDERATION BELOW (AT LEAST ONE OPTION REQUIRED)
<input type="checkbox"/> New EP
<input type="checkbox"/> Hospital-Based EP – An EP is considered to be hospital-based if he or she provides 90% or more of their covered professional services in either an inpatient (Place of Service 21) or emergency department (Place of Service 23)
<input type="checkbox"/> Provider Enrollment, Chain, and Ownership System (PECOS) related issues
<input type="checkbox"/> Change of Ownership delay
<input type="checkbox"/> Revalidation delay
<input type="checkbox"/> Exempt PECOS primary specialty code – EPs with the following designated as their primary specialty in PECOS are not subject to the payment adjustment: 05-Anesthesiology, 22-Pathology, 30-Diagnostic Radiology, 36-Nuclear Medicine, 94-Interventional Radiology
<input type="checkbox"/> Experienced a 2017 Hardship Issue
<input type="checkbox"/> EP was approved a 2017 Hardship or is exempt from the payment adjustment AND received the 2017 payment adjustment letter
<input type="checkbox"/> Certified Electronic Health Record Technology (CEHRT) Vendor Issues



INDICATE THE TYPE OF RECONSIDERATION BELOW (Continued)

Meaningful use attestation issues for 2015

Closure of EP practice

Ineligible Provider (i.e. Nurse Practitioner or Physician's Assistant)

Provide a brief description of the Reconsideration type indicated:



SECTION 4: ATTESTATION

GENERAL NOTICE

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

SIGNATURE OF ELIGIBLE PROFESSIONAL

I certify that the information contained herein is true, accurate, and complete. I understand that the Medicare EHR Incentive Program payment adjustment reconsideration may result in a change in the amount I will be paid from Federal Funds, and that by filling this application I am submitting a claim for Federal funds, and the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a Medicare EHR Incentive Program payment adjustment reconsideration, may be prosecuted under applicable Federal or state criminal laws and may also be subject to civil penalties.

SUBMITTER WORKING ON BEHALF OF A PROVIDER: I certify that I am submitting this application for a payment adjustment reconsideration on behalf of a provider who has given me authority to act as his/her agent. I understand that both the provider and I can be held personally responsible for all information entered.

I hereby agree to keep such records as are necessary to support the application submitted for a payment adjustment reconsideration of the Medicare EHR Incentive Program and to furnish those records both in the application and at a future time upon request from the Department of Health and Human Services, or a contractor acting on their behalf.

No Medicare EHR Incentive Program reconsideration may be granted unless this application is completed and approved as required by existing law and regulations (42 CFR §495.102).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this application may be subject to fine and imprisonment upon conviction under applicable Federal laws.

ROUTINE USE(S): Information from this Medicare EHR Incentive Program payment adjustment reconsideration application and subsequently submitted information and documents may be given to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment of any overpayment made and to Congressional offices in response to



inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local and foreign government agencies, private business entities and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation relation to the operation of the Medicare EHR Incentive Program.

DISCLOSURES: This program is an incentives program. Therefore, while submission of information for this program is voluntary, failure to provide necessary information will result in delay in processing the payment adjustment reconsideration application or may result in a denial of a payment adjustment reconsideration for the Medicare EHR Incentive Program payment. Failure to furnish subsequently requested information or documents to support this attestation may result in overpayments and the issuance of an overpayment demand letter followed by recoupment procedures.

It is mandatory that you tell us if you believe you have been overpaid under the Medicare EHR Incentive Program. The Patient Protection and Affordable Care Act, Section 6402, Section 1128J, provides penalties for withholding this information.

By confirming this certification statement, I agree and express my intent to sign this application and affirmation by including my name and the date below. I understand that completing the information below is the legal equivalent of having placed my handwritten signature on the submitted application and this affirmation.

Confirm*

*Date (MM/DD/YYYY):

*Type name of individual completing form:

- This completed application and all supporting documentation must be attached to an email and sent to pareconsideration@provider-resources.com. Please ensure that you have saved the application on your computer and have attached it and any supporting documentation to the body of the email prior to submission.
- As a last resort, this application and all supporting documentation can be submitted via fax to **814-464-0147**.
- The submission deadline for this application is **February 28, 2017**.