2018 ELIGIBLE HOSPITAL
PAYMENT ADJUSTMENT RECONSIDERATION APPLICATION
FOR MEDICARE ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

Complete this application **only** if the Eligible Hospital receives a letter from CMS stating that the Eligible Hospital is subject to the 2018 Medicare EHR payment adjustment and you feel that the payment adjustment is in error.

The submission deadline for this 2018 Medicare EHR Incentive Program payment adjustment reconsideration application is December 15, 2017.

SECTION 1: HOSPITAL INFORMATION

Provide the following information regarding the Eligible Hospital that is applying for payment adjustment reconsideration for the Medicare EHR Incentive Program. Fields marked with * are required.

Legal Hospital Name*	
CMS' Certification Number (CCN) (6 digits)*	
National Provider Identifier (NPI) (10 digits)*	

Hospital Address Line 1 (Street Name and Number – Not a Post Office Box)*		
Hospital Address Line 2 (Suite, Room, etc.)		
City/Town*	State* (2 character code)	Zip Code (5 digit)*
Email Address* (this is how we will communicate with you)		
Submitter First Name*	Submitter Last Name*	
Business Telephone Number (include Area Code)*	Extension	

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

Has the Eligible Hospital previously demonstrated meaningful use?

☐ Yes – The Eligible Hospital previously demonstrated meaningful use.
Indicate in which program year(s) below:

- ☐ 2016
- ☐ 2015
- ☐ 2014
- ☐ 2013
- ☐ 2012
- ☐ 2011

☐ No – The Eligible Hospital has not previously demonstrated meaningful use.

INDICATE THE TYPE OF PAYMENT ADJUSTMENT RECONSIDERATION BELOW (AT LEAST ONE OPTION REQUIRED)
☐ Provider Enrollment, Chain, and Ownership System (PECOS) processing delays ☐ Change of Ownership delay ☐ Revalidation delay
☐ New Facility
☐ Experienced a 2018 Hardship Issue
☐ Eligible Hospital was approved a 2018 Hardship or is exempt from the payment adjustment AND received the 2018 payment adjustment letter in error
☐ Certified Electronic Health Record Technology (CEHRT) Vendor Issue
☐ Meaningful Use attestation issues for 2016
☐ Closure of Facility
☐ Ineligible Facility

Provide a brief description of the Reconsideration type indicated:

SECTION 3: CERTIFICATION STATEMENT CONFIRMATION

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 HOSPITAL REPRESENTATIVE

I certify that the information contained herein is true, accurate, and complete. I understand that the Medicare EHR Incentive Program payment adjustment reconsideration I requested may result in a change in the amount the hospital represented will be paid from Federal funds, and that by filling this payment adjustment reconsideration 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 HOSPITAL: I certify that I am submitting this application for a payment adjustment on behalf of a hospital who has given me authority to act as his/her agent. I understand that both the hospital 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 exception 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 upon conviction be subject to fine and imprisonment 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,

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 in 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 payment adjustment reconsideration for the Medicare EHR Incentive Program. 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 it is 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 EH submission deadline for this application is **December 15, 2017**.