

**MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD
7500 Security Boulevard, Mailstop B1-01-31
Baltimore, MD 21244**

STATEWIDE APPLICATION

Reclassification Period: FFYs _____

Please read the MGCRB rules before completing this application.

This application must be fully completed and timely received by the MGCRB in accordance with 42 C.F.R. §§ 412.235 and 412.256 and Board Rules. Failure to comply may result in dismissal.

This application must also be sent to CMS via e-mail at wageindex@cms.hhs.gov. Delivery to CMS does not constitute delivery to the MGCRB.

General Information

Statewide Information

State: _____

Representative Information

Identify the representative contact for all communications regarding the application:

Name: _____

Organization: _____

Address: _____

City, State, Zip: _____

E-mail Address: _____

Telephone Number: _____

Note: OMB Approval 0938-0573 (Expires 02/28/2029); estimated burden 1 hour

Listing of Providers

Under a tab labeled "Providers," the statewide representative must provide a listing of all participating acute care inpatient prospective payment system ("IPPS") hospitals in the state. The listing is to be submitted in the following format:

Column A	Column B	Column C	Column D
Provider Number	Provider Name	Provider Address	Did provider also file an individual or group application? (Y/N)

All IPPS hospitals in the state must agree to the reclassification to a statewide wage index through a signed affidavit. **Under a tab labeled "Affidavits,"** attach an affidavit for each participating provider in accordance with 43 C.F.R. § 412.235.

Under a tab labeled "Representative" or "Rep," attach a letter of representation for each participating provider in accordance with Board Rule 2.4.

Note: The Board will rule on a statewide request first and then a group reclassification request before it reviews any individual reclassification request. If the Board approves the statewide application, it will dismiss any group or individual reclassification applications filed by participating providers.

Background Questionnaire

Note: All required documentation as noted by the questions below must be annotated with the applicable question number and included **under a tab labeled "Background."**

1. Are all the acute care inpatient prospective payment system ("IPPS") providers in the state listed as members of the statewide application?

Yes No

Attach support that identifies all the IPPS providers in the state.

If no, attach an explanation that identifies which provider(s) are excluded and the basis for the exclusion.

2. Are the providers in the statewide application requesting an oral hearing?

Yes No

If yes, attach a letter of rationale for the oral hearing request.

Certification Statements

*I certify that I have read and am familiar with Board statutes, regulations, and rules and, to the best of my knowledge, the application is filed in full compliance with such statutes, regulations, and rules.

*I understand that an omission, misstatement, or error made in the statewide application and supporting information may be grounds for denial of the statewide application.

*I certify that I am authorized to file an application on behalf of the listed statewide group.

Signature: _____

Representative Name: _____

Organization: _____

Date: _____

**HOSPITAL AFFIDAVIT FOR
STATEWIDE WAGE INDEX RECLASSIFICATION**

State of _____

County or parish of _____

I, _____ (type or print name),
being duly sworn, depose and say as follows:

- (1) I certify that _____
(Provider's name and Medicare provider number) ("the hospital") agrees to be included in the
statewide wage index reclassification request for the State of _____
for the federal fiscal years _____.
- (2) I understand that all prospective payment system hospitals in the state must apply as a group
for reclassification to a statewide wage index through a signed single application.
- (3) I understand that all prospective payment system hospitals in the state must agree to the
reclassification to a statewide wage index through a signed affidavit on the application.
- (4) I understand that all prospective payment system hospitals in the state must agree, through
an affidavit, to withdrawal of an application or to termination of an approved statewide wage
index reclassification.
- (5) I understand that the hospital waives its rights to any wage index classification that it would
otherwise receive absent the statewide wage index classification, including a wage index that it
might have received through individual geographic reclassification.
- (6) I certify that I am an officer of the hospital or a corporate officer of the hospital's parent
corporation with authority to sign this affidavit for the hospital's inclusion in the statewide wage
index reclassification request.

Signature: _____

Title: _____

Phone number: _____

E-mail address: _____

Subscribed and sworn to before me

This _____ day of _____, 20____

Notary Public

My commission expires: _____