ELIGIBLE HOSPITAL APPEAL FILING REQUEST
BASIC INFORMATION REQUEST

COMPLETE SECTIONS 1, 2, 3, AND 4 FOR ALL APPEAL TYPES

SECTION 1: HOSPITAL INFORMATION

Section 1.1 – Provide the following information regarding the hospital that is filing an appeal for the Medicare EHR Incentive Program (fields marked with * are required)

Legal Hospital Name*		
National Provider Identifier (NPI) (10 digits)*	CMS Certification Number (CCN) (6 digits)*	
Hospital Address Line 1 (Street Name and Number – Not a Post Office Box or Hospital Name)*		
Hospital Address Line 2 (Suite, Room, etc.)		
City/Town*	State (2 character code)*	Zip Code (5 digits)*
Email Address* (This is how we will communicate with you.)		
Business Telephone Number (Include Area Code)*	Extension	

Section 1.2 – Provide the information below for the person working on behalf of the hospital applying for the hardship exception for the Medicare EHR Incentive Program. All return correspondence will be sent to the contact(s) listed in sections 1.1 and 1.2. All required fields are indicated with an asterisk*

First Name*	Middle Initial	Last Name*	Suffix (i.e. Jr., Sr.)
Email Address (This is how we will communicate with you.)*			

SECTION 2: HOSPITAL APPEAL REQUEST TYPE SELECTION

Review the information below and indicate the type of appeal being filed

REASON FOR APPEAL	FILING REQUEST INFORMATION
☐ **Failed Audit Meaningful Use Appeal** ☐ Prepayment ☐ Postpayment	Allows a hospital to demonstrate meaningful use by addressing each of the failed measures. Appeals must be filed within 30 days from the date of the adverse audit determination letter.
☐ **Failed Reporting Meaningful Use Appeal**	Allows a hospital to show that certified electronic health record technology (CEHRT) was used to successfully demonstrate meaningful use but failed due to a reporting issue. Appeals must be filed within 30 days after the attestation deadline.
☐ **CQM e-Reporting Meaningful Use Appeal**	Allows a hospital to show that Clinical Quality Measures (CQM) e-reporting was successful in meeting meaningful use. Appeals must be filed within 30 days after the attestation deadline.
☐ **Eligibility Appeal**	Allows a hospital to show that all EHR Incentive Program requirements were met and that the hospital should have been able to register and attest for the Program but could not due to circumstances outside the hospital's control. Examples include: unable to register by deadline. Appeals must be filed within 30 days after the attestation deadline.

Year for Appeal	**2011** ☐ **2012** ☐ **2013** ☐ **2014** ☐ **2015** ☐ **2016** ☐ **Select only one year per appeal request**
Stage for Appeal	☐ **Stage 1** ☐ **Stage 2**

SECTION 3: HOSPITAL APPEAL FILING REQUEST INFORMATION

Based on the appeal type selected in Section 2, complete the appropriate information below

Failed Audit Meaningful Use Appeal (complete all information below)

- Include documentation that justifies the specific reasons for this failed audit appeal and explain how the documentation addresses each of the failed measures or other failed audit findings
- Do not resubmit documentation that was previously requested by or submitted to the auditor. CMS will not review appeal documentation for hospitals who failed to respond to the auditor's request for documentation
- Only include additional documentation related to the justification for the appeal with this request, and make sure that the documentation dates correspond to the reporting period
- CMS will review the audit findings along with submitted appeal documentation
- For additional audit documentation guidance, please refer to: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_SupportingDocumentation_Audits.pdf

Documentation submitted Includes:

☐ CEHRT proof of purchase (date, version number and hospital information)*

Dated reports/screenshots from CEHRT that validate:

☐ Core Measures and/or Exclusions
☐ Menu Measures and/or Exclusions
☐ Security risk analysis performed prior to the end of the reporting period
☐ Patient list by condition from the EHR reporting period; patient-identifiable information (PII) should be masked before submission
☐ A zero denominator for the excluded measures and additional documentation that justifies the exclusion
☐ Documentation of a test submission to the registry or public health agency (whether successful or unsuccessful) that includes hospital information

Dated letter or email:

☐ From immunization registry or public health agency confirming receipt or failure of receipt, including date of submission and name of parties transmitting data
☐ From vendor verifying CEHRT possession or other measures

Failed Reporting Meaningful Use Appeal (complete all information below)

Did the hospital successfully register for the Medicare EHR Incentive Program?
☐ Yes ☐ No

Did the hospital successfully attest for the Medicare EHR Incentive Program?
☐ Yes ☐ No

Please state the EHR reporting period:

EHR reporting period start date: (MM/DD/YYYY) _____

EHR reporting period end date: (MM/DD/YYYY) _____

Did the hospital's CEHRT output incorrect data?
☐ Yes ☐ No

What is the basis of the hospital's appeal?

_____

Documentation submitted Includes:
☐ Dated reports from hospital's CEHRT that validate core and menu measures
☐ CEHRT proof of purchase (including date, version number and hospital information)*

CQM e-Reporting Meaningful Use Appeal (complete all information below)

What is the basis of the hospital's appeal?

_____

Documentation submitted Includes:
☐ Dated reports from hospital's CEHRT that validate CQM submission
☐ CEHRT proof of purchase (including date, version number and hospital information)*

Eligibility Appeal (complete all information below)

Did the hospital successfully register for the Medicare EHR Incentive Program?

☐ Yes ☐ No

Did the hospital successfully attest for the Medicare EHR Incentive Program?

☐ Yes ☐ No

Please state the 90-day EHR reporting period:

EHR reporting period start date: (MM/DD/YYYY) _____

EHR reporting period end date: (MM/DD/YYYY) _____

What is the basis of the hospital appeal?

_____

Reason the hospital was unable to register for the EHR Incentive Program:

- ☐ Unable to register by deadline
- ☐ Other:

_____

Documentation submitted includes: (*required)

- ☐ CMS-855 Application, Medicare Administrative Contractor (MAC) document control number and any correspondence validating that the Provider Enrollment Chain and Ownership System (PECOS) application was filed, including date of submission
- ☐ Internet-based PECOS web tracking identification number or proof of contact
- ☐ CEHRT proof of purchase (including date, version number and hospital information)*
- ☐ Additional documentation: Please provide an explanation for additional documentation.

SECTION 4: CERTIFICATION STATEMENT FOR APPEAL FILING REQUEST

Read the certification statement below and confirm the following:

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 HOSPITAL REPRESENTATIVE OR ELIGIBLE PROFESSIONAL

I certify that the foregoing information is true, accurate, and complete. I understand that the Medicare EHR Incentive Program appeal may result in a change in the amount the hospital will be paid from Federal Funds, and that by filling this appeal, 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, 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 request for an appeal 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 appeal submitted for the Medicare EHR Incentive Program and to furnish those records both in the appeal 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 appeal may be granted unless this request 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 appeal may upon conviction be subject to fine and imprisonment under applicable Federal laws.

ROUTINE USE(S): Information from this Medicare EHR Incentive Program appeal 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 responses 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 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 appeal or may result in a denial of an appeal for the Medicare EHR Incentive Program. Failure to furnish subsequently requested information or documents to support this attestation may result in overpayment 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 request 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 request and this affirmation.

☐ **Confirm***

*Date (MM/DD/YYYY):

*Type name of individual completing form: