Centers for Medicare & Medicaid Services **Standard Term Request Form**	Date of Request

After completing this form, e-mail the request to DataAdmin@cms.hhs.gov

Central/Local DA Name				Date Required *(mm/dd/yyyy)*
Project Name (if applicable)	Project Acronym	Project Owner	Business Owner	Component/Group/Division

TERM	*(Check one)* ☐ New ☐ Change
	Proposed TERM · Proposed TERM Abbreviation ☐ Acronym?
	TERM Role: ☐ Object Class Term ☐ Qualifier Term ☐ Property Term ☐ Representation Class Term

TERM DEFINITION	

EXAMPLE OF TERM USAGE	

DATA ANALYST JUSTIFICATION	

Glossary Administrator *(First and Last Name)*	Date Completed *(mm/dd/yyyy)*