Hospital Contact Change Form

If there are no updates to be made, please do not submit this form.

Complete and submit this form only if any of the contact types indicated below have changed in your facility**. If there are no updates to be made, please do not submit this form.** Provide information only for the contact type(s) that need to be replaced, added, updated, or removed. If a contact type does not apply, please leave the section blank or indicate not applicable (N/A). When requesting a change to a contact type, if the Type of Contact Change (i.e., Add New to Replace Existing, Add Additional, Update Existing, or Remove Existing) is not selected, the current contact information in the system for the specified contact type will be removed and replaced with the new information listed on this form.

Form may be sent by email to QRFormsSubmission@hsag.com

Date: _____ Provider Name: _____ Provider ID/CMS Certification Number (CCN): _____

Name/Title of Person Completing the Form: _____/_____Phone Number: _____

Click here to view your Facility's current contacts.

Change 1					
Type of Contact Change	**Contact Type**	**Contact Name**	**Title**	**Telephone Number**	**Email Address**
Choose an Option	Choose an Option				
If applicable add the name of the person being replaced here:					
Change 2					
Type of Contact Change	**Contact Type**	**Contact Name**	**Title**	**Telephone Number**	**Email Address**
Choose an Option	Choose an Option				
If applicable add the name of the person being replaced here:					
Change 3					
Type of Contact Change	**Contact Type**	**Contact Name**	**Title**	**Telephone Number**	**Email Address**
Choose an Option	Choose an Option				
If applicable add the name of the person being replaced here:					
Change 4					
Type of Contact Change	**Contact Type**	**Contact Name**	**Title**	**Telephone Number**	**Email Address**
Choose an Option	Choose an Option				
If applicable add the name of the person being replaced here:					
Change 5					
Type of Contact Change	**Contact Type**	**Contact Name**	**Title**	**Telephone Number**	**Email Address**
Choose an Option	Choose an Option				
If applicable add the name of the person being replaced here:					

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Change 6					
Type of Contact Change	**Contact Type**	**Contact Name**	**Title**	**Telephone Number**	**Email Address**
Choose an Option	Choose an Option				
If applicable add the name of the person being replaced here:					

Change 7					
Type of Contact Change	**Contact Type**	**Contact Name**	**Title**	**Telephone Number**	**Email Address**
Choose an Option	Choose an Option				
If applicable add the name of the person being replaced here:					

Change 8					
Type of Contact Change	**Contact Type**	**Contact Name**	**Title**	**Telephone Number**	**Email Address**
Choose an Option	Choose an Option				
If applicable add the name of the person being replaced here:					

Change 9					
Type of Contact Change	**Contact Type**	**Contact Name**	**Title**	**Telephone Number**	**Email Address**
Choose an Option	Choose an Option				
If applicable add the name of the person being replaced here:					

Change 10					
Type of Contact Change	**Contact Type**	**Contact Name**	**Title**	**Telephone Number**	**Email Address**
Choose an Option	Choose an Option				
If applicable add the name of the person being replaced here:					

*Important note about *QualityNet* SAs: Every facility participating in the Hospital IQR Program and/or IPFQR Program must designate a minimum of one SA. To prevent possible interruption of *QualityNet* access, facilities are highly encouraged to appoint at least two SAs. If your facility does not have an SA, it may be at risk of incurring a reduction to its annual payment update (APU). **For more information about how to designate an SA, please refer to the *QualityNet* Security Administrator Registration page. Please Note: Submitting SA contact information on this form WILL NOT update or change your SA information in *QualityNet*.**

Click here to submit form via Internet Explorer.

For all other browsers, download and send form by email to QRFormsSubmission@hsag.com.

Acronyms					
APU	Annual Payment Update	**ID**	Identification	**PCHQR**	PPS-Exempt Cancer Hospital Quality Reporting
CDAC	Clinical Data Abstraction Center	**NHSN**	National Health and Safety Network	**SA**	Security Administrator
CEO	Chief Executive Officer	**IPFQR**	Inpatient Psychiatric Facility Quality Reporting	**SO**	Security Official
CMS	Centers for Medicare and Medicaid Services	**IQR**	Inpatient Quality Reporting		
CCN	CMS Certification Number	**OQR**	Outpatient Quality Reporting		