



HHA CONTACT FORM – UPDATES

CCN#: _____
 Facility Name: _____
 Address: _____
 City, State, Zip: _____
 Phone #: _____

Address Change: _____

Phone Change: _____

Please print clearly and **COMPLETE** all fields to ensure accuracy.
 Please include mailing address for each contact if it is different from the facility address above.

CEO/ADMINISTRATOR: Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____	MEDICAL RECORDS CONTACT: Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____
MPRO LIAISON: Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____	FAST TRACK APPEALS: Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____
QUALITY IMPROVEMENT/HCQIP CONTACT: Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____	MEDICAL DIRECTOR: Dr/Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____

Quality Improvement/HCQIP Contact: The person in your facility who will work closely with the Health Care Quality Improvement Project Manager at MPRO.

MPRO Liaison: Person in your facility who will be the contact with MPRO staff. This person will receive all correspondence related to your facility. This correspondence includes: adverse determinations, approvals, administrative memoranda, and policy changes.

Fast Track Appeals: Primary contact for concurrent reviews or Fast Track Appeals

 CEO/Administrator Signature

 Date

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