



HOSPICE CONTACT FORM – UPDATES

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

Address Change: _____

Phone Change: _____

Please print clearly and fill in 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: _____	MEDICAL DIRECTOR: Dr/Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____
HCQIP CONTACT: Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____	FAST-TRACK APPEALS CONTACT: Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____

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.

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

Medical Records Contact: The provider designee for whom all requests for medical records should go to.

Medical Director: The medical director for your facility.

 CEO/Administrator Signature

 Date

FAX to: (248) 465-7428 Please return within 15 days ATTN: Lynn Samsel
 Mail to: MPRO, ATTN: Lynn Samsel 22670 Haggerty Rd., Ste. 100, Farmington Hills, MI 48335