



### SNF 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.

<b>CEO/ADMINISTRATOR:</b> Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____	<b>MDS/DATA COORDINATOR:</b> Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____
<b>QUALITY IMPROVEMENT/HCQIP CONTACT:</b> Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____	<b>MPRO LIAISON:</b> Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____
<b>DIRECTOR OF NURSING:</b> Mr/Mrs/Ms _____ Title: _____ Phone: _____ FAX: _____ E-mail: _____	<b>FAST-TRACK APPEALS CONTACT:</b> 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.

**MDS/Data Coordinator:** MDS Coordinator

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

\_\_\_\_\_  
**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