HHA CONTACT FORM

Provider Name: ____

CMS Certification Number (CCN): ____________

Provider Phone Number: ______________________

If any contact person below needs mail to be sent to an address **other than the provider address** please indicate in the blank spaces at bottom of next page. Thank you.

<u>There is a brief explanation of the categories below at the end of this form</u>.

To ensure accuracy, **please print clearly** and complete all fields.

CEO/ADMINISTRATOR: Mr/Mrs/Ms____________________________ Title: ________________________________ Phone: ______________________________ FAX: _______________________________ E-mail: ______________________________	**MEDICAL RECORDS CONTACT**: Mr/Mrs/Ms ____________________________ Title: ________________________________ Phone: ______________________________ FAX: _______________________________ E-mail: ______________________________
CFO: Mr/Mrs/Ms____________________________ Title: ______________________________ Phone: ______________________________ FAX: _______________________________ E-mail: ______________________________	**MEDICAL DIRECTOR**: Dr/Mr/Mrs/Ms__________________________ Title: ______________________________ Phone ______________________________ FAX: ______________________________ E-mail: ______________________________
MPRO LIAISON: Mr/Mrs/Ms____________________________ Title: ______________________________ Phone: ______________________________ FAX: _______________________________ E-mail:______________________________	**INFORMATION TECH**: <u>Mr</u>/Mrs/Ms ____________________________ Title: ________________________________ Phone: ______________________________ FAX: _______________________________ E-mail: ______________________________
HCQIP (QUALITY) CONTACT: Mr/Mrs/Ms____________________________ Title: ______________________________ Phone: ______________________________ FAX: _______________________________ E-mail:______________________________	**OASIS DATA COORDINATOR**: Mr/Mrs/Ms____________________________ Title: ______________________________ Phone: ______________________________ FAX: _______________________________ E-mail:______________________________
DIRECTOR OF NURSING: Mr/Mrs/Ms____________________________ Title: ______________________________ Phone: ______________________________ FAX: _______________________________ E-mail:______________________________	**FAST-TRACK APPEALS CONTACT** Mr/Mrs/Ms____________________________ Title: ______________________________ Phone: ______________________________ FAX: _______________________________ E-mail:______________________________

STAFF EDUCATION NURSE: Mr/Mrs/Ms______________________________ Title: ________________________________ Phone: _______________________________ FAX: ________________________________ E-mail:_______________________________	

HCQIP contact: The person in your facility who will work closely with the Health Care Quality Improvement Project Manager at MPRO.
Hospital Discharges Appeals Contact (Fast-Track): Primary contact for concurrent reviews or discharge notices for appeals
Information Technology Contact: The provider designee for which concerns regarding information technology can be directed by MPRO information technology staff.
Medical Director: The medical director for your facility.
Medical Records Contact: The provider designee for whom all requests for medical records should go to.
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.
Oasis Data Coordinator: Cart Administrator, MDS Coordinator, Oasis Coordinator, etc…
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PLEASE RETURN **AGREEMENT TO TERMS PAGE** AND **CONTACT FORM WITHIN 30 DAYS**

MPRO
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Farmington Hills, MI 48335-2611
Fax: 248-465-7428