Payer Performance Submitting Entity Information

CLEAR FORM

Hospital/Health System Name:	
EHR/HIS	
Business Contact	This is the primary business contact for the facility's use of or access to information in relation to the payer data feed
Name:	
Contact Title:	
Email:	
Primary Phone:	
Technical Contact	This is the primary technical contact related to the facility's use of or access to information in relation to the payer data feed
Name:	
Contact Title:	
Email:	
Primary Phone:	

Hospital/Health System Name:	

Facilities included	**Facility ID (CMS Certification Number or NPI Preferred)**

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By signing below, I warrant that I have the requisite authority to authorize and have obtained applicable consents to authorize the disclosure of data, including protected health information, from the above-designated facilities to HIDI for services contemplated by the HIDI master agreement between the above-designated facilities and HIDI. I acknowledge that it is the responsibility of Hospital/Health System to identify, authorize and monitor the access rights of Hospital/Health System's end users who are permitted to access, use or submit data. I also acknowledge the responsibility to safeguard protected health information that can be downloaded or printed in accordance with the Standards for Privacy of Individually Identifiable Health Information found at 45 C.F.R. Parts 160 and 164, Subparts A and E and the Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Parts 160 and 164, Subparts A and C. The individuals identified on this form are HIDI's primary contacts related to Hospital/Health System's use of or access to information in relation to the payer data feed.

I authorize the above-named individuals to receive access to the specified data.

CEO Name:

CEO Signature: _____ **Date:**

Please complete and return the completed form to HIDI@MoHospitals.org.