



Provider News

December 7, 2016

HEDIS 2017 – Provider Medical Record Location and Contact Form

HEDIS 2017 is just around the corner and the Alliance's Quality Improvement team is hard at work planning for the medical record review process.

To reduce the burden of medical record requests on providers and avoid erroneous or duplicative requests, please complete the form on the following page and return to:

Britta Vigurs

email: bvigurs@ccah-alliance.org

fax: (209) 381-5307

by Friday, December 16, 2016



Return To: Britta Vigurs, Central California Alliance for Health
 email: bvigurs@ccah-alliance.org or fax: (209) 381-5307

Please return by December 16, 2016

Medical Record Location (address where medical record request should be sent)	
Practice/Facility Name:	
Street Address:	Primary Contact:
City/State, Zip	Title:
Phone Number:	Fax Number:
Email Address:	
Is your practice's main HEDIS contact different than the medical record contact listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide this person's name and contact information.	Name: Title: Phone Number: Email address:
Electronic Medical Record (EMR) Usage	
Does your practice use an Electronic Medical Record system? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name of the EMR and the year implemented. EMR Name: Year Implemented:	Would you prefer to have patient medical record data reviewed via remote EMR access instead of individual fax requests? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who should we contact to obtain access? Name: Title: Phone Number: Email address:
Immunization Registry Usage	
Does your practice enter immunizations into a registry? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, are you interested in receiving training on how to use the registry? <input type="checkbox"/> Yes <input type="checkbox"/> No
Laboratory Usage	
Does your practice use an external provider for administering and/or processing laboratory tests? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name(s) of any laboratories used during the past 3 years (2014, 2015 & 2016).	Laboratory Name: Laboratory Name: Laboratory Name: