



**MEDICAID ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE PROGRAM
AUDIT REPORT APPEAL REQUEST**

Submit completed form to: EHR_audit_appeals@hhsc.state.tx.us

SECTION 1: ELIGIBLE HOSPITAL (EH) CONTACT INFORMATION

Section 1 – Provide the following information regarding the EH that is filing an appeal request for the Medicaid EHR Incentive Program (fields marked with * are required). The contact information provided below will be used to communicate with the EH during the appeal. It is the EH’s responsibility to notify the Texas Health and Human Services Commission (HHSC) of any changes to this information.

Eligible Hospital Name*	
Point of Contact First Name*	Point of Contact Last Name*
Point of Contact Title	
Hospital Individual National Provider Identifier (NPI) (10 digits)*	

Hospital Address Line 1 (Street Name and Number – <u>Not</u> a Post Office Box)*		
Hospital Address Line 2 (Suite, Room, etc.)		
City/Town*	State* (2 character code)	Zip Code (5 digits)*
Email Address* (<u>This is how HHSC will communicate with the EH regarding the appeal.</u>)		
Business Telephone Number (Include Area Code)*		Extension

Which Program Year Audit are you appealing?*	<input type="checkbox"/> 2011 <input type="checkbox"/> 2012 <input type="checkbox"/> 2013 <input type="checkbox"/> 2014 <input type="checkbox"/> 2015
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SECTION 2: AUTHORIZED REPRESENTATIVE CONTACT INFORMATION

Section 2 – If the EH is designating a non-affiliated third-party representative (law firm, etc.) in this appeal, please provide the information below for the authorized representative working on behalf of the EH. If a contact person is listed below, all correspondence related to this appeal will be sent to the email and mailing address listed in Section 2 as well as Section 1 above.

First Name	Middle Initial	Last Name	Suffix (i.e. Jr., Sr.)
Entity/Organization Name			
Address Line 1 (Street Name and Number – <u>Not</u> a Post Office Box)			
Address Line 2 (Suite, Room, etc.)			
City/Town	State (2 character code)	Zip Code (5 digits)	
Email Address			
Business Telephone Number (Include Area Code)		Extension	

SECTION 3: APPEAL SUBMISSION INSTRUCTIONS

Which Audit Report are you appealing? *	<input type="checkbox"/> Draft Audit Report - See Section 3.1 <input type="checkbox"/> Final Audit Report - See Section 3.2
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All Section 3 requirements must be submitted to HHSC at: EHR_audit_appeals@hhsc.state.tx.us

Section 3.1 - Draft Audit Report Appeal - In addition to this completed form, to submit an appeal of a Draft Audit Report, please attach only a written memorandum that includes within it the following appeal information:

- 1.) Draft Audit Report detailed finding(s) being appealed (cite number of the deficiency/finding from the Audit Report)
- 2.) Explanation of why, according to the EH, the audit finding(s) is/are incorrect.

The memorandum must not exceed 10 pages (one sided) using a font no smaller than 12 point. Any additional documentation submitted beyond what is requested above will not be reviewed or considered during the appeal.

Section 3.2 - Final Audit Report Appeal - To appeal a Final Audit Report, this completed form must be submitted to the email address indicated in this section above. No additional documentation should be submitted at this time. HHSC will email a confirmation receipt and provide additional instructions regarding the Final Audit Report appeal criteria and process.

SECTION 4: CERTIFICATION STATEMENT - APPEAL REQUEST

Section 4- Read the information and certification statement below and confirm the following:

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

It is the responsibility of the EH or the EH's authorized representative to submit an appeal prior to the 30-day deadline by completing an Audit Report Appeal Request Form. Per Section 3.1, Draft Audit Report appeal requests must be submitted with an EH memorandum attached. As detailed in Section 3.2, only the completed Audit Report Appeal Request Form is needed to request a Final Audit Report appeal. HHSC will issue further instructions relating to the Final Audit Report appeal upon receipt of this form.

If an HHSC receipt confirmation email is not received by the EH or its authorized representative within three business days following submission of this form to HHSC, it is the responsibility of the EH or the authorized representative to ensure the documentation was received prior to any deadlines.

All appeal-related documents from HHSC will be delivered via two methods to the EH or the EH's authorized representative, if applicable, as follows: email (primary method) and United States Postal Service certified mail (secondary method).

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I certify that the foregoing information is true, accurate, and complete. I understand that this Medicaid EHR Incentive Program appeal may result in a final determination in which the EH must refund an overpayment of incentive funds to HHSC, including recoupment through Medicaid claims payments.

AUTHORIZED REPRESENTATIVE WORKING ON BEHALF OF AN EH:

I certify that I am submitting this request for an appeal on behalf of an EH who has given me authority to act as his or her agent. I understand that both the EH and I will be held responsible for all information submitted.

By confirming this certification statement, I agree to the foregoing statement, and it is my intent, to sign this request for an appeal.

Confirm*

Date (mm/dd/yyyy)*:

Print name of EH or EH authorized representative*:

Signature of EH or EH authorized representative*:

DO NOT WRITE BELOW THIS LINE
