



# RY2017 MassHealth Acute Hospital Pay-for-Performance Program: Hospital Quality Contact Form

**Instructions.** Pursuant to Section 7 of Acute Hospital RFA, each Hospital must submit information on all staff involved in quality reporting during the Rate Year. Please complete all information required for each designated staff in blank spaces provided under each section header. Enter N/A if vendors are not applicable. The form must be signed by one of the hospital key representatives to confirm information entered is current as of the date submitted. All information must be typed in this PDF form using Adobe Reader version 5 or higher. Go to <https://get.adobe.com/reader/> to download Adobe Acrobat Reader DC.

<b>HOSPITAL NAME</b>			<b>HOSPITAL CEO NAME</b>		
Street address			Phone	Fax	
City	State	Zip code	E-mail		

### Hospital Key Representatives

<b>Key Quality Contact Name</b>		Position Title/Dept.			E-mail	
Mailing address	City	State	Zip Code	Phone	Fax	
<b>RFA Manager Contact Name</b>		Position Title/Dept.			E-mail	
Mailing address	City	State	Zip Code	Phone	Fax	

### Authorized MassQEX Portal Users

<b>Hospital Staff Name</b>	Position Title/Dept.	E-mail	Phone	Fax
<b>Hospital Staff Name</b>	Position Title/Dept.	E-mail	Phone	Fax
<b>Hospital Staff Name</b>	Position Title/Dept.	E-mail	Phone	Fax
<b>Vendor User Name</b>	Agency/Title	E-mail	Phone	Fax
<b>Vendor User Name</b>	Agency/Title	E-mail	Phone	Fax
<b>Vendor User Name</b>	Agency/Title	E-mail	Phone	Fax

**Key Representative Signature:** \_\_\_\_\_ **Enter Date Submitted:** \_\_\_\_\_

#### Mailing Instructions

Hospitals must mail the original signed form and supporting documentation with a typed cover letter on hospital stationery to the address on the right.

EOHHS MassHealth Office of Providers and Plans  
**Attention:** Acute Hospital P4P Program  
100 Hancock Street (6th floor)  
Quincy, MA 02171