2015 HARDSHIP EXCEPTION APPLICATION – due 11/30/2014

MEDICARE 2015 ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM INFORMATION

Check one box and complete the following required sections.

Eligible Professionals

- ☐ Doctor of medicine or osteopathy
- ☐ Doctor of optometry
- ☐ Doctor of dental surgery or dental medicine
- ☐ Chiropractor
- ☐ Doctor of podiatry

Medicare Subsection (d) Eligible Hospitals

- ☐ Hospital qualified for or participating in the Medicare EHR Incentive Program
- ☐ Medicare Advantage (MA) Organization representing an MA-Affiliated Hospital qualified for or participating in the Medicare EHR Incentive Program
- ☐ Hospital qualified to participate in both Medicare and Medicaid EHR Incentive Programs

(fields marked with * are required)

Name*		
Address Line 1 (Street Name and Number – not a Post Office Box)*		
Address Line 2 (Suite, Room, etc.)		
City/Town*	State*	Zip Code*
Email Address (required unless unavailable)*		
Business Telephone Number (include Area Code)*		Extension
National Provider Identifier (NPI) (10 digits)*	CMS Certification Number (CCN) (6 digits)hospitals only	
EHR Technology Product Name(s) and Version Number		

CMS EHR Certification ID provided by the Office of the National Coordinator (ONC) via http://onc-chpl.force.com/ehrcert. If product no longer has a Certification ID, please provide prior Certification ID.*

If applicable, provide the information below for the person working on behalf of the provider applying for the Hardship Exception for the EHR Incentive Program. (fields marked with * are required).

First Name*	Middle Initial	Last Name*	Suffix
Mailing Address Line 1*			
Mailing Address Line 2			
City/Town*	State*	Zip Code*	
Email Address (required unless unavailable)*			
Business Telephone Number (include Area Code)*		Extension	

Unforeseen and/or Uncontrollable Circumstances: EHR Certification/Vendor Issues

☐ 2014 EHR Vendor Certification Issues and Delays

Has the provider previously demonstrated Meaningful Use*?

☐ Yes if yes, for what year_____

☐ No

Name of EHR product and version number or vendor that has lost certification or closed or been delayed in obtaining 2014 certification* (please note that if the EHR product is not yet certified, you will not be able to list a specific CEHRT number here. In this case, please provide whatever product information is available.):

_____

Read the certification statement below and confirm the following:

GENERAL NOTICE

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.

SIGNATURE OF PROVIDER

I certify that the foregoing information is true, accurate, and complete. I understand that the Medicare EHR Incentive Program Hardship Exception I requested will request in a change in the amount I will be paid from Federal Funds, and that by filling this Hardship Exception I am submitting a claim for Federal Funds, and the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a Medicare EHR Incentive Program Hardship Exception, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

SUBMITTER WORKING ON BEHALF OF A PROVIDER: I certify that I am submitting this Application for a Hardship Exception on behalf of a provider who has given me authority to act as his/her agent. I understand that both the provider and I can be held personally responsible for all information entered.

I hereby agree to keep such records as are necessary to support the Application submitted for a Hardship Exception of the Medicare EHR Incentive Program and to furnish those records both in the Application and at a future time upon request from the Department of Health and Human Services, or a contractor acting on their behalf.

No Medicare EHR Incentive Program exception may be granted unless this Application is completed and approved as required by existing law and regulations (42 CFR §495.102).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this Application may upon conviction be subject to fine and imprisonment under applicable Federal laws.

ROUTINE USE(S): Information from this Medicare EHR Incentive Program Hardship Exception Application and subsequently submitted information and documents may be given to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment of any overpayment made and to Congressional Offices in responses to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local and foreign government agencies, private business entities and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation relation to the operation of the Medicare EHR Incentive Program.

DISCLOSURES: This program is an incentives program. Therefore, while submission of information for this program is voluntary, failure to provide necessary information will result in delay in processing the Hardship Exception application or may result in a denial of a Hardship Exception for the Medicare EHR Incentive Program payment. Failure to furnish subsequently requested information or documents to support this attestation may result in overpayments and the issuance of an overpayment demand letter followed by recoupment procedures.

It is mandatory that you tell us if you believe you have been overpaid under the Medicare EHR Incentive Program. The Patient Protection and Affordable Care Act, Section 6402, Section 1128J, provides penalties for withholding this information.

By confirming this certification statement, I agree, and it is my intent, to sign this Application and affirmation by including my name and the date below. I understand that completing the information below is the legal equivalent of having placed my handwritten signature on the submitted Application and this affirmation.

☐ **Confirm***

*Date (MM/DD/YYYY):_____

*Type name of individual completing form: _____

If you are printing out this form, please provide your handwritten signature below.

Signature:

_____

- This completed application must be attached to an email and sent to **ehrhardship@provider-resources.com**
- For EPs without Internet connectivity, submit this application and all supporting documentation via fax to **814-464-0147**.
- Submit your application no later than 11:59 PM EST November 30, 2014.