**Hospital Contact Form**



**NOTICE:** It is important to notify us quickly when contacts change

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Position/Contact Type** | **Full Name** | **Prof.**  **Suffix** | **Title** | **Mailing Address**  (if different from above) | **Email Address** | **Telephone & Fax**  **(list fax for Liaison and Quality)** |
| Hospital CEO or CFO |  |  |  |  |  | T: F: n/a |
| Hospital Medical Director |  |  |  |  |  | T: F: n/a |
| Hospital-assigned Liaison |  |  |  |  |  | T: F: |
| Hospital-assigned Quality Contact |  |  |  |  |  | T: F: |
| Hospital-assigned Web Administrator |  |  |  |  |  | T: F: n/a |
| 2nd Web Administrator |  |  |  |  |  | T: F: n/a |
| 1st Retro Chart Contact Email |  |  |  |  |  | T: F: n/a |
| 2nd Retro Chart Contact Email |  |  |  |  | 0000000000000 | T:  F: n/a |

***\*\*ONLY FILL IN THE CONTACTS YOU WANT US TO UPDATE\*\****

**Send completed form to:**

Acentra Health (formerly eQ/Kepro)

Attn: Provider Education & Outreach

Fax: (800) 418-4039

**Hospital CEO or CFO Signature eQHealth Liaison Signature Date**

(**MUST be signed for Liaison change**) (Required for Web Administrator or Quality Contact)

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **12-DIGIT HFS BILLING PROVIDER ID** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Hospital Name:** |  | | | | | | | | | | | |
| **Hospital Address:** |  | | | | | | | | | | | |
| **City, State & Zip:** |  | | | | | | | | | | | |