Hospital Contact Form

All information must be complete for processing

NOTICE: It is important to notify eQHealth Solutions immediately when contacts change

(12-DIGIT PROVIDER ID REQ'D)												
Hospital Name:												
Hospital Address:												
City, State & Zip:												

Send completed form to:
eQHealth Solutions
Attn: Provider Education & Outreach
Fax: (800) 418-4039

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

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

Hospital CEO or CFO Signature
(**MUST be signed for eQHealth Liaison change**)

eQHealth Liaison Signature
(Required for Web Administrator or Quality Contact)

Date