**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:** |  |