A close up of a logo

Description automatically generated**Office of Management Information Services**

**Hospital Inpatient Uniform Billing Data Request Form**

To request a report or data for Hospital Inpatient Uniform Billing Data, submit this form to: DHHRReportRequests@wv.gov. Depending on the nature of the request, DHHR may require external entities to sign a Memorandum of Understanding (MOU) and/or a Data Use Agreement (DUA).

### Requestor Information

Name and Title

|  |
| --- |
| Click here to enter text. |

**Organization**

|  |
| --- |
| Click here to enter text. |

**Type of Organization**

|  |
| --- |
| Choose an item. |

*Other*

|  |
| --- |
| Click here to enter text. |

Address

|  |
| --- |
| Click here to enter text. |

Email and Phone Request Date

|  |  |  |
| --- | --- | --- |
| Click here to enter text. |  | Click here and select arrow. |

Is there a specific deadline for this request due to a reporting requirement, meeting, etc.?

*Please allow at least 30 days for approval*

|  |  |  |
| --- | --- | --- |
| Choose Yes or No. | **If *Yes*, select a due date:** | Click here and select arrow. |

### Business Objective

Describe the purpose or business objective of the report.

|  |
| --- |
| Click here to enter text. |

**Detailed description of how the report will be used?**

|  |
| --- |
| Click here to enter text. |

### Custom Dataset and Report Specifications

**Select Data Fields Requested**

*See separate file labeled “Reports Reference Manual” or* *“Office of Management Information Services*

*Reports Reference” for additional information*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Year(s):  2016  2017  2018  2019 |  | Payor Group:  Commercial Self-Pay  Medicare  Government  PEIA |
|  | Admission Type |  | MS-DRG |
|  | Age Group (0-17, 18-44, 45-64, 65-74, 75+) |  | Newborn Indicator |
|  | Attending Physician |  | Patient County |
|  | Discharge Disposition/Status |  | Patient County |
|  | Discharge Month |  | Patient State |
|  | Discharge Quarter |  | Patient Zip Code |
|  | Race |  | Primary Diagnosis |
|  | Gender |  | Primary Procedure |
|  | Hospital |  | Revenue Code |
|  | Hospital ID |  | Secondary Diagnosis |
|  | Length of Stay |  | Service Area |
|  | MDC |  | Source of Admission/Point of Origin |
|  | Place of Service  Acute medical/surgical unit (non-PPS exempt)  Psychiatric unit or facility  Medical rehabilitation unit or facility |  | Total Charges |

Data will be delivered via Secure File Transfer Protocol.

Data Export Format:  xlsx  csv  pdf

List any additional report specifications related to content or design. Include specific definitions or logic that should be applied. Supporting documents may be attached.

|  |
| --- |
| Click here to enter text. |

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_