**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_