DATA REQUEST

West Virginia Health Care Authority
100 Dee Drive
Charleston, WV 25311-1600
Phone 304.558.7000 Fax 304.558.7001
Web Site www.hcawv.org

Data Request #
Received By:_____ Date:_____
Referred To:_____ Date:_____
Entered:_____

Notice: Any failure to disclose the information as requested in this application, misrepresentation, or omission as to intent will be grounds for refusal of your request.

Name_____ Title_____

Organization_____

Address _____

Phone Number_____ Fax _____

E-Mail Address_____

Billing Address (if Different): _____

PURPOSE OF REQUEST: - Please state the purpose of this request in the lines below. Failure to complete this portion of the Application will result in its return, which will delay the processing of your request. (Please attach additional sheets as needed.)

☐ Certificate of Need Application ☐ Rate Review ☐ Research

_____

_____

1. Will you be reselling the data or analysis in any form? _____ (Yes or No)
2. Will you use the data for consulting purposes? _____ (Yes or No)
3. a. Will you be conducting research with the data? _____ (Yes or No)
   (if data are to be used for research purposes, attach a copy of your study protocol.)
   b. Are you receiving grant funding for this project? _____ (Yes or No)
   c. If yes, please provide name of sponsor(s) or funding organization: _____
4. Will you be publishing the data in any way ? (if yes, a specific Data Use Agreement may be required) _____ (Yes or No)
5. Will you be using the data for litigation or in any way to take legal action based on your findings from the use of the data? _____ (Yes or No)
6. a. Will you be disclosing the data to any Third Party? _____ (*see definitions below)
   b. If yes, please provide the following information:

Name of Third Party: _____ Title _____

Organization: _____

Address: _____

Telephone: _____Fax:_____

If more than one third party will be involved, please attach Information on separate sheet.

DEFINE THE SCOPE OF THE REQUEST:

Type of Reports: ☐ Custom or ☐ Standard

Indicate type of Customized Output Format: ☐ ASCII comma delimited: ☐ ASCII tab delimited: ☐ Excel ☐ MS Access ☐ SAS ☐ OTHER: (Contact Data Requests staff for feasibility and approval.)

Standard data files are available on CD-ROM as Adobe PDF format or ASCII Flat Text only. (See list)

In the space below (or on an attached list), please specify the exact file names, documents, or criteria for the data set or report. Please be as specific as possible and include geographic scope (by regions or zip codes), clinical scope (MDCs, DRGs, ICD-9 codes, or combination), and/or hospital scope (bed size, type, or names), and list of variables desired (e.g. DRG, Total Charges, Primary Diagnosis). Please attach additional sheets as needed.

Year(s) of data requested: _____

Scope:

_____

_____

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• For the purposes of this application:

Use is defined as the sharing, employment, application, utilization, examination or analysis of such data within the organization filing this request and named above.

Disclosure is defined as the release, transfer, provision of access to, or divulging in any other manner the data requested pursuant to this data request to any third party.

Third party is defined as any entity other than the organization filing request filing this request and named above, including but not limited to vendors, contractors, and consultants.

Signature: _____