1. Name and Address of State Agency       2. Name and Address of Hospital         3. Provider Number       RO Complaint Control Number       4. Hospital Accredited By:         3. Provider Number       DO NOT INFORM THE HOSPITAL OF THE SURVEY         5. In Complaint Cases, Type of Emergency (check all that apply)         a Labor       Other OB         6. Source of Complaint (check all that apply)         a Patient or Patient's Family       Quality Improvement Organization         B Receiving Hospital       Other (specify)         7. In Complaint Cases, Type of Complaint (check all that apply)       Congressional Inquiry         7. In Complaint Cases, Type of Complaint (check all that apply)       Congressional Inquiry         7. In Complaint Cases, Type of Complaint (check all that apply)       Transferr         a Physician on-call list       Policies/Procedures       Transfer         B Physician on-call list       Policies/Procedures       Transfer         B Prostical Records       Reporting Requirement       Whistleblower         C Recipient Hospital Responsibilities       Delay in Examination or Treatment       Central Log         A copy of the allegation is enclosed. The name of the complainant should not be disclosed without specific	REQUEST FOR SURVEY OF §489.20 AND §489.24 ESSENTIALS OF PROVIDER AGREEMENTS: Responsibilities of Medicare Participating Hospitals in Emergency Cases			
JCAHO       AOA       Nonaccredited         DO NOT INFORM THE HOSPITAL OF THE SURVEY         5. In Complaint Cases, Type of Emergency (check all that apply)         Labor       Other OB       Medical       Trauma       Psychiatric       Surgical       Other         6. Source of Complaint (check all that apply)       Quality Improvement Organization       Other       Other         6. Source of Complaint (check all that apply)       Quality Improvement Organization       Other         7. In Complaint Cases, Type of Complaint (check all that apply)       Other (specify)       Transferring Hospital       Other (specify)         7. In Complaint Cases, Type of Complaint (check all that apply)       Policies/Procedures       Transfer         Screening       Treatment       Posting of Signs         Medical Records       Reporting Requirement       Whistleblower         Recipient Hospital Responsibilities       Delay in Examination or Treatment       Central Log	1. Name and Address of State Agency	2. Name and Address of Hospital		
DO NOT INFORM THE HOSPITAL OF THE SURVEY         DO NOT INFORM THE HOSPITAL OF THE SURVEY         5. In Complaint Cases, Type of Emergency (check all that apply)         Labor       Other OB         Medical       Trauma         Psychiatric       Surgical         Other OB       Medical         Trauma       Psychiatric         Source of Complaint (check all that apply)         Patient or Patient's Family       Quality Improvement Organization         Receiving Hospital       Medicare Intermediary         Transferring Hospital       Other (specify)         Congressional Inquiry       Other (specify)         Policies/Procedures       Transfer         Screening       Treatment       Posting of Signs         Medical Records       Reporting Requirement       Whistleblower         Recipient Hospital Responsibilities       Delay in Examination or Treatment       Central Log	3. Provider Number RO Complaint Contr	rol Number 4. Hospital Accredited By:		
5. In Complaint Cases, Type of Emergency (check all that apply)		□ JCAHO □ AOA □ Nonaccredited		
Labor       Other OB       Medical       Trauma       Psychiatric       Surgical       Other         6. Source of Complaint (check all that apply)       Quality Improvement Organization         Patient or Patient's Family       Quality Improvement Organization         Receiving Hospital       Medicare Intermediary         Transferring Hospital       Other (specify)         Congressional Inquiry       Other (specify)         Physician on-call list       Policies/Procedures       Transfer         Screening       Treatment       Posting of Signs         Medical Records       Reporting Requirement       Whistleblower         Recipient Hospital Responsibilities       Delay in Examination or Treatment       Central Log	DO NOT INFO	RM THE HOSPITAL OF THE SURVEY		
<ul> <li>Receiving Hospital</li> <li>Transferring Hospital</li> <li>Other (specify)</li> <li>Congressional Inquiry</li> </ul> 7. In Complaint Cases, Type of Complaint (check all that apply) <ul> <li>Physician on-call list</li> <li>Policies/Procedures</li> <li>Transfer</li> <li>Screening</li> <li>Treatment</li> <li>Posting of Signs</li> <li>Medical Records</li> <li>Recipient Hospital Responsibilities</li> <li>Delay in Examination or Treatment</li> <li>Central Log</li> </ul> A copy of the allegation is enclosed. The name of the complainant should not be disclosed without specific	6. Source of Complaint (check all that apply)			
<ul> <li>Physician on-call list</li> <li>Policies/Procedures</li> <li>Transfer</li> <li>Screening</li> <li>Treatment</li> <li>Posting of Signs</li> <li>Medical Records</li> <li>Recipient Hospital Responsibilities</li> <li>Delay in Examination or Treatment</li> <li>Central Log</li> </ul> A copy of the allegation is enclosed. The name of the complainant should not be disclosed without specific	<ul> <li>Receiving Hospital</li> <li>Transferring Hospital</li> </ul>	Medicare Intermediary		
	<ul> <li>Physician on-call list</li> <li>Screening</li> <li>Medical Records</li> </ul>	<ul> <li>Policies/Procedures</li> <li>Treatment</li> <li>Reporting Requirement</li> <li>Treatment</li> <li>Whistleblower</li> </ul>		
Due to the serious nature of this complaint, please conduct the survey within 5 working days of notification.	authorization.			

Signature of Regional Administrator or Designee	Region	Date