DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

REQUEST FOR SURVEY OF §489.20 AND §489.24 ESSENTIALS OF PROVIDER AGREEMENTS:

Responsibilities of Medicare Participating Hospitals in Emergency Cases

1. Name and Address of State Agency	2. Name and Address of Hospital

3. Provider Number	RO Complaint Control Number	4. Hospital Accredited By:
		☐ 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)*

- ☐ Patient or Patient's Family
- ☐ Receiving Hospital
- ☐ Transferring Hospital
- ☐ Congressional Inquiry
- ☐ Quality Improvement Organization
- ☐ Medicare Intermediary
- ☐ Other *(specify)*

7. In Complaint Cases, Type of Complaint *(check all that apply)*

- ☐ Physician on-call list
- ☐ Screening
- ☐ Medical Records
- ☐ Recipient Hospital Responsibilities
- ☐ Policies/Procedures
- ☐ Treatment
- ☐ Reporting Requirement
- ☐ Delay in Examination or Treatment
- ☐ Transfer
- ☐ Posting of Signs
- ☐ Whistleblower
- ☐ Central Log

A copy of the allegation is enclosed. The name of the complainant should not be disclosed without specific authorization.

Due to the serious nature of this complaint, please conduct the survey within 5 working days of notification.

Signature of Regional Administrator or Designee	Region	Date