Telligen
Quality Innovation Network-Quality Improvement Organization (QIN-QIO)
Physician Practice Quality Improvement
Learning and Action Network
Participation Agreement Enrollment Form

☐ Cardiac Health ☐ Diabetes ☐ Quality Payment Program
☐ Antibiotic Stewardship ☐ Immunizations

Practice Name: _____
Address: _____Suite #: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____
Practice TAX ID Number: _____
Practice Specialty: _____ Number of Office Locations: _____
EHR Vendor and Product: _____
EHR Version: _____
Is your practice part of a health system and/or Medicare ACO? _____
Is your practice connected to an HIE? (Yes or No) _____ If yes, which one?_____
Do you have a patient portal? (Yes or No) _____
Clinical Quality Measures your practice will be reporting in 2017: _____
_____

Participation Agreement Signature

Practice Representative Name: _____
Practice Representative Title: _____
Practice Representative E-mail: _____
Authorized Representative Signature: _____ Date: _____

Required for Antibiotic Stewardship Initiative only:

Clinical Lead Name: _____
Clinical Lead Signature: _____ Date: _____
Staff Champion Name: _____
Staff Champion Signature: _____ Date: _____

Please send this completed and signed Participation Agreement Enrollment Form to:

Attention: Devon Parris
Email: Devon.Parris@area-D.hcqis.org
Phone: 443-561-3471
Fax: 443-561-3401

This material was prepared by Telligen, Medicare Quality Innovation Network Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-QIN-10/14-014

Provider Name	Credentials (MD, DO, DDS, PA, NP)	Specialty	NPI#