LTCH CARE Manual Assessment Deletion Request

NOTE: Assessment item errors for reasons other than an incorrect FAC_ID, must be corrected and resubmitted using **Correction Policy** procedures.

Please Type or Print Legibly

All Fields are Required

Provider Information

LTCH Name: (complete name)

LTCH Facility ID:

Requestor (Administrator/Owner) Information

Name (full name):

Title:

E-mail Address:

Phone Number:

Patient Information

First Name:

Last Name:

SSN:

Patient's Medicare Number:

Resident ID:*

Record Information

Target Date:

Assessment ID:*

Submission Information

Submission Date:

Submission ID:*

Reason for Deletion

Reason for Deletion Request:

* RES_INT_ID, ASMT_ID, and SUBMISSION ID are found on the Final Validation Report

Signature - Administrator or Owner (Please circle one)

Date

Submit **completed** and **signed** form to the IQIES Service Center by **Certified Mail** through the US Postal Service.

GDIT
iQIES Service Center
4800 Westown Pkwy., suite 360
West Des Moines, IA 50266

For security reasons, this information **must not** be e-mailed, faxed, or sent by regular first class mail. This form **must** be sent by **Certified Mail** only.

iQIES Service Center - Internal Use:
