

# QIES (MDS/PBJ) Third-Party Service Bureau User Request

This form must be completed by a facility in order to:

1. **Designate a third-party service bureau user** to submit assessments and/or staffing information on the facility's behalf
2. **Remove access** of a current third-party service bureau user to the facility in situations such as termination or turnover

**A Third-Party Service Bureau is defined as follows:** An outside entity contracted by the facility or a corporation to provide services. The entity is typically contracted to process submissions, but may also be contracted to retrieve and/or review report data for facilities. The entity is not limited to contracting with facilities in a single state and may provide services for facilities in multiple states.

**Warning:** Security regulations do not allow a user ID to be logged on to multiple sessions simultaneously. Problems may arise if the third-party service bureau user ID is used with an automated submission system and accesses multiple servers.

**NOTE:** For a state license-only facility, please provide the Facility ID used for submissions in lieu of the Medicare CCN.

**Please complete this form, in its entirety, electronically**

**Note:** In order to e-mail this form, you must first save it as a text file. Instructions for downloading and saving PDF forms are available at <https://qtso.cms.gov/access-forms/data-access-request-information>.

## Type of Request (REQUIRED)

Request to Create New Third Party Personal User ID for:

- MDS Submission  
 Payroll Based Journal (PBJ)

Request to Change:

- Add Facility  
 Remove Facility

Third Party User's Current Personal ID:

## Third-Party User Information (REQUIRED)

First & Last Name:	<input type="text"/>	User Phone:	<input type="text"/>
User E-mail Address:	<input type="text"/>		
User Physical Address:	<input type="text"/>		
Company Name:	<input type="text"/>		

## Facility Information (REQUIRED)

(of the facility for which data will be submitted or reports requested)

Facility Name:	<input type="text"/>		
Medicare CCN or Facility ID:	<input type="text"/>	<input type="checkbox"/> Check if Facility is State License-Only (Medicaid Only)	
Facility Physical Address:	<input type="text"/>		
Facility Mailing Address:	<input type="text"/>		
Facility Contact Person Name:	<input type="text"/>	Contact Person Phone:	<input type="text"/>
Contact Person Title:	<input type="text"/>		
Contact Person E-mail Address:	<input type="text"/>		
Request Date:	<input type="text"/>		

### Fax OR e-mail the completed form to the Help Desk

**E-mail submissions must include facility letterhead as an attachment**

**E-mail: [iqies@cms.hhs.gov](mailto:iqies@cms.hhs.gov)**

**Fax cover sheet must contain facility letterhead and must come from a facility fax machine**

**Fax: 888-477-7871**

After submitting the request, if you do not receive e-mail acknowledgment within 2 business days, please contact us immediately

**Please allow 5 business days for your request to be completed**