NOTE: Assessment item errors, other than those listed below, must be
corrected and resubmitted using **Correction Policy** procedures.

Please Type or Print Legibly
All Fields are Required

☐ **Delete Test Record**   ☐ **Correct A0410 Value**   ☐ **Delete Wrong FAC_ID**   ☐ **Not CMS Required*****

Facility Information

Facility Name:
(complete name)

ID (FAC_ID):

Requestor (Administrator/Owner) Information

Name (full name):

Title:

E-mail Address:

Phone Number:

Resident Information

First Name:

Last Name:

SSN:

Birth Date:

Gender:

Resident ID:*

Record Information

A0310A Value: A0310B Value: A0310C Value: A0310D Value: A0310F Value:

Target Date:**

Assessment ID:*

Submission Information

Submission Date:

Submission ID:*

A0410 (Submission Requirement) Values

Submitted (Incorrect) Value:

Correct Value:

* RES_INT_ID, ASMT_ID, and SUMISSION ID are found on the
   Final Validation Report
** Target Date is:
   MDS Item **A2300** (Assessment Reference Date) for an
   assessment record
   MDS Item **A2000** (Discharge Date) for a discharge
   record MDS Item **A1600** (Entry Date) for a reentry record

*** Record is not for OBRA and not for Medicare Part A PPS

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

_____ _____
Signature - Administrator or Owner (Please circle one)   Date
Submit **completed** and **signed** form to your State Agency via **Certified
Mail** through the US Postal Service. Your State Agency will approve, sign,
and forward your request to the iQIES Service Center.

_____ _____
Signature - State Agency Authorizer   Date

The request must be sent **Certified Mail** through the US Postal Service.

All requests require State Agency authorization.
Forms forwarded to the iQIES Service Center without a State Agency signature will be rejected.

iQIES Service Center - Internal Use: