

**Attention: Rhonda Ritchey**  
 eQHealth Solutions  
 (formerly Louisiana Health Care Review)  
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 Fax (225) 925-0342  
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Provider Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 Medicare Provider Number: \_\_\_\_\_ NPI: \_\_\_\_\_ Main Phone Number: \_\_\_\_\_  
 Website: \_\_\_\_\_

**Contact Definitions:**

1. Liaison (**QI Liaison/Director**) - This person will be the main contact to receive information regarding the Quality Improvement Initiative(s) that eQHealth Solutions is working on in this Scope of Work. This contact will also receive all newsletters and general correspondence regarding quality improvement in the hospital arena.
2. **Medical Records Contact** - This person receives all correspondence related to Case Review; (Medical Chart Requests from eQHealth and CDAC, Notice of Potential Letter, Notice of Final Letter, Newsletters, etc.). Also, this person is someone we can contact to get necessary information regarding the facility.
3. Administrators will receive MOA contracts, newsletters, and contact forms.
4. All the other contacts listed on the form are sometimes cc'd on letters that are usually sent to the primary contacts or sent "FYI" information that could be useful to them.

Function / Position	Contact Name	Prof. Suffix	Title	Phone	Fax	E-mail Address
Administrator / CEO (REQUIRED)						
CFO						
QI Liaison / Director (REQUIRED)						
Medical Records Contact (REQUIRED)						
Medical Director / Chief of Staff						
Director of Nursing						

Provider Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_


<b>Function / Position</b>	<b>Contact Name</b>	<b>Prof. Suffix</b>	<b>Title</b>	<b>Phone</b>	<b>Fax</b>	<b>E-mail Address</b>
Compliance Officer						
Director of Infection Control						
Wound Care Specialist						
JCAHO Contact						
Communications/Marketing Director						
Medical Staff Credentialing Contact						

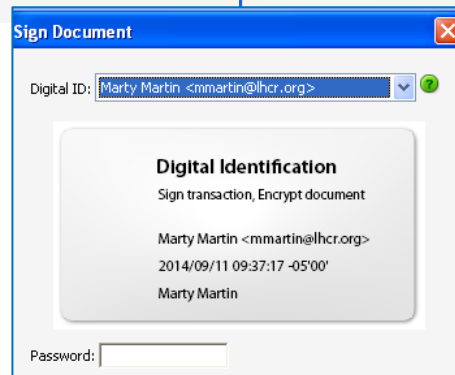
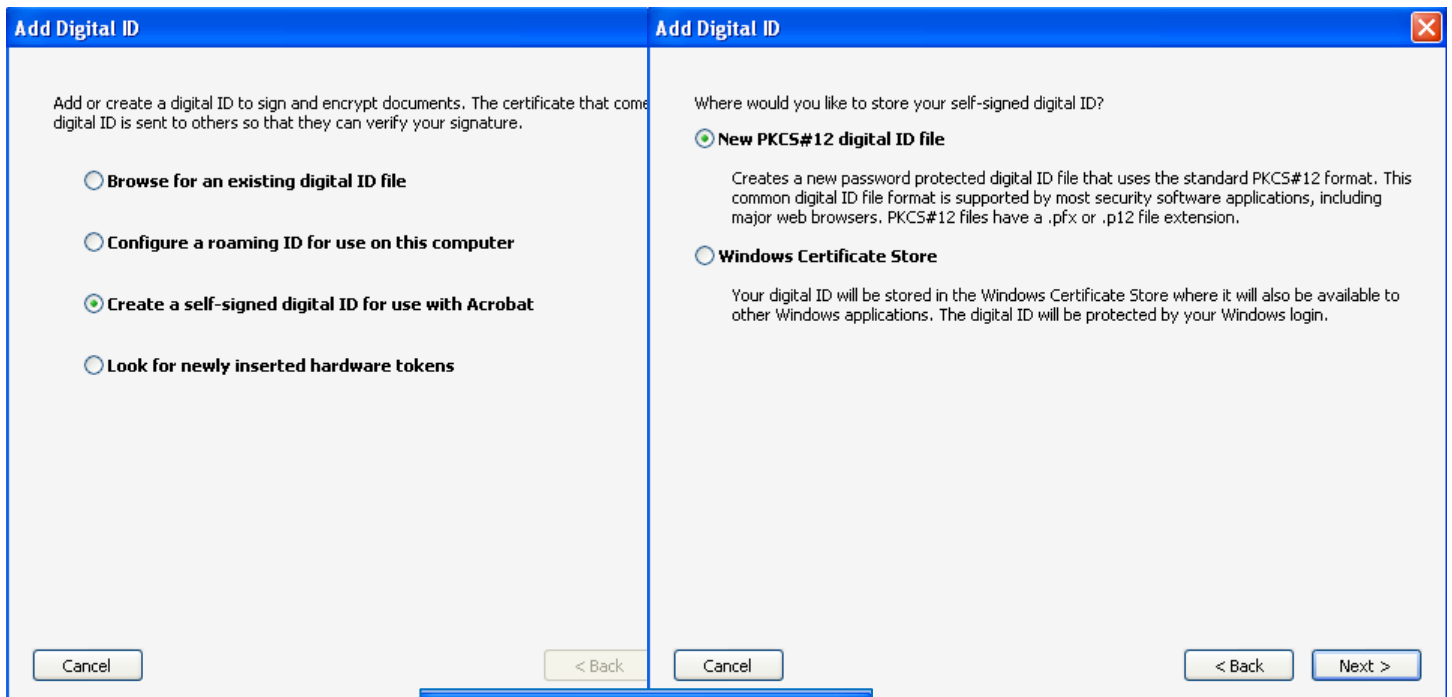
Name of person completing form (PLEASE PRINT): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**FORM MUST BE SIGNED BY HOSPITAL ADMINISTRATOR**

1. Click on the “SIGNATURE” field to initiate the digital signature process
  - a. If you already have a digital signature you should be prompted to sign the field
  - b. IF Not, The “Add Digital ID” window will appear. The process takes less than a minute so please take the time to complete
    - i. Choose “Create a self-signed digital ID for use with Acrobat” and click Next
    - ii. Then choose “New PKCS digital ID file” and click Next
    - iii. Fill in your name, Department, Organization Name and Email. Leave the other fields set to the defaults and click Next
    - iv. Enter your chosen password
    - v. confirm your password and click Finish to save to the default location
  - c. Enter your password into the field and click Sign
  - d. Choose a folder to save the document in for your own records and click Save
  - e. Click on the Email icon in the Adobe Reader toolbar 
  - f. Choose “Desktop Email application.
  - g. Click “Send”



Add Digital ID

Add Digital ID



Enter your identity information to be used when generating the self-signed certificate:

Name (e.g. John Smith):

Organizational Unit:

Organization Name:

Email Address:

Country/Region:

Enable Unicode Support

Key Algorithm:

Use digital ID for:

Enter a file location and password for your new digital ID file. You will need the password when you use the digital ID to sign or decrypt documents. You should make a note of the file location so that you can copy this file for backup or other purposes. You can later change options for this file using the Security Settings dialog.

File Name:

Password:

Confirm Password: