It is a Violation of the CMS Security Policy to share User IDs

Nursing Home Electronic Plan of Correction (ePOC) Account Request
ePOC User Account Additions and Updates

NOTE: This form shall be used for the following purposes**:**

1. **Remove ePOC access** from a single-facility user account(s).
2. **Add or remove ePOC access** for a user account(s) established to process for multiple facilities.

***Please complete this form electronically and submit to the* QTSO Help Desk** (see page 5)

ePOC User 1

First & Last Name (*Required*):

E-mail Address (*Required*): Phone:

Action Requested (*Select One*)

☐ Add ePOC Access (*Specify*): ☐ New User ☐ Existing MDS User Existing User Account ID:

☐ Remove ePOC Access for Existing User Account ID:

User 1 Facility Assignment - *Indicate Action for each of the following facility(ies)*

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

☐ **Check if contact information is same as above**

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

☐ **Check if contact information is same as above**

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

ePOC User 1 *Continued*

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

☐ **Check if contact information is same as above**

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

ePOC User 2

First & Last Name (*Required*):

E-mail Address (*Required*): Phone:

Action Requested (*Select One*)

☐ Add ePOC Access (*Specify*): ☐ New User ☐ Existing MDS User Existing User Account ID:

☐ Remove ePOC Access for Existing User Account ID:

User 2 Facility Assignment - *Indicate Action for each of the following facility(ies)*

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

☐ **Check if contact information is same as above**

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

☐ **Check if contact information is same as above**

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

ePOC User 2 *Continued*

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

☐ **Check if contact information is same as above**

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

ePOC User 3

First & Last Name (*Required*):

E-mail Address (*Required*): Phone:

Action Requested (*Select One*)

☐ Add ePOC Access (*Specify*): ☐ New User ☐ Existing MDS User Existing User Account ID:

☐ Remove ePOC Access for Existing User Account ID:

User 3 Facility Assignment - *Indicate Action for each of the following facility(ies)*

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

☐ **Check if contact information is same as above**

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

☐ **Check if contact information is same as above**

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

ePOC User 3 *Continued*

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

☐ **Check if contact information is same as above**

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

ePOC User 4

First & Last Name (*Required*):

E-mail Address (*Required*): Phone:

Action Requested (*Select One*)

☐ Add ePOC Access (*Specify*): ☐ New User ☐ Existing MDS User Existing User Account ID:

☐ Remove ePOC Access for Existing User Account ID:

User 4 Facility Assignment - *Indicate Action for each of the following facility(ies)*

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

☐ **Check if contact information is same as above**

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

☐ **Check if contact information is same as above**

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

ePOC User 4 *Continued*

☐ Add ☐ Remove ☐ Increase Max Number of ePOC Users (Max number of user is 4) Request Date:

Facility Name: Medicare CCN:

Address:

☐ **Check if contact information is same as above**

Contact Person First and Last Name (*Required*):

Title:

E-mail Address (*Required*): Phone:

Fax OR e-mail the completed form to the **QTSO Help Desk**

QTSO Help Desk Fax: **888-477-7871** QTSO Help Desk E-mail: **help@qtso.com**

Note: It is required that the fax cover sheet contain facility letterhead and that the fax be sent from a facility fax machine.

Please allow 5 business days for processing