

Medical Record Retrieval and Electronic Medical Record Questionnaire

Provider Group
Name: _____

Address: _____ **City/ST:** _____ **Zip:** _____

 Please complete this form and email within 5 business days to TX_Medicaid_QI@bcbstx.com.

Be sure to include:

- Your group's contact for medical record retrieval related to Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and
- Information about your group's electronic medical record system so that we can request remote access to our members' charts. This streamlines the process and minimizes disruptions to your office.

Who is your Quality Improvement / HEDIS Contact?				Title:			
Is that person available Mon-Fri?		Y / N		Phone number: ()		Fax: ()	
Do you have an EMR System?		Y / N		Type of EMR System (Epic, NexGen, etc.):			
Do you have multiple sites who use the same system?			Y / N		Can it be accessed from one location?		Y / N
Can it be accessed by the BCBSTX Medicaid Division remotely?				Y / N			
Who is the point of contact to arrange remote access?						Title:	
Phone number: ()		Email Address:					
Do you use a 3rd party to manage medical records? If so, which one? (CIOX, ScanSTAT, etc.)							
Do you have a contact at the 3rd party?							
Any Instructions:							
Completed by:				Title:		Date: / /	

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