Affinia Health Network

MIPS Support Request Form

CONTACT INFORMATION

OFFICE NAME

PRIMARY CONTACT NAME

TITLE

PHONE NUMBER

EMAIL ADDRESS

EHR VENDOR (IF APPLICABLE)

QCDR VENDOR (IF APPLICABLE)

PCMH DESIGNATION STATUS

HOW WOULD YOU LIKE US TO HELP?

WHEN ARE YOU AVAILABLE (DATES AND TIMES)?

PLEASE SAVE AND EMAIL REQUESTS TO: JOHN.LUTERBACH@MERCYHEALTH.COM