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PROVIDER INSTRUCTIONS
1) Fill out all fields except the signature line.
2) Print the form. You may not be able to save it.
3) Sign the form. The provider associated with the NPI must sign the form.
4) Scan and email the completed and signed form to your email address here.

Practice Information

Practice Name			
Address Line 1			
Address Line 2			
City/ST/Zip			
Phone/Ext			

By signing this document the provider identified in the signature section below authorizes Clinigence, LLC an authorized EHR Data Submission Vendor, to submit on the provider's behalf patient-specific data on Medicare beneficiaries to CMS for the purpose of 2013 PQRS participation.

Provider TIN

Provider NPI

Provider (printed)

Provider (signature)

Date (mm/dd/yyyy)