



**HOSPITAL DISCHARGE APPEALS
CONTACT INFORMATION FORM**

In order that we may contact the appropriate person regarding a beneficiary's request for an appeal, please provide the following information. Thank you.

Hospital Name: _____ Hospital Provider #: _____

Address: _____

Fiscal Intermediary: _____

CONTACT PERSON DURING REGULAR WORKING HOURS

(Primary Contact) Name: _____

Title: _____ Direct Phone #: _____

Facsimile #: _____ Cell Phone #: _____

(Secondary Contact, if applicable) Name: _____

Title: _____ Direct Phone #: _____

Facsimile #: _____ Cell Phone #: _____

WEEKEND CONTACT PERSON

(Primary Contact) Name: _____

Title: _____ Direct Phone #: _____

Facsimile #: _____ Cell Phone #: _____

(Secondary Contact, if applicable) Name: _____

Title: _____ Direct Phone #: _____

Facsimile #: _____ Cell Phone #: _____

Please complete and fax this form to:

QSource

ATTN: Frances Richardson

FAX #: 901.273.2659

Or mail to:

QSource

ATTN: Frances Richardson

3175 Lenox Park Blvd., Ste. 309

Memphis, TN 38115