

# MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION PHYSICIAN UPDATE FORM

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|                |            |          |
|----------------|------------|----------|
| Practice Name: | DOQ-IT ID: | MCMP ID: |
|----------------|------------|----------|

PLEASE ADD OR REMOVE THE BELOW PHYSICIANS FROM THE MCMP DEMONSTRATION:

| Add/Remove | Physician Name | Tax Identification Number | Medicare Provider Identification Number (PIN) at this Location | NPI –National Provider Identification | Effective Date |
|------------|----------------|---------------------------|--|---------------------------------------|----------------|
|            |                |                           |  |                                       |                |
|            |                |                           |  |                                       |                |
|            |                |                           |  |                                       |                |
|            |                |                           |  |                                       |                |
|            |                |                           |  |                                       |                |

**ALL NEW PHYSICIANS MUST SIGN THEIR OWN CONSENT FORM**

Lead Physician/Authorized Contact Person

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Once you have completed this form please send the original to:**

**MCMP Demonstration  
c/o Actuarial Research Corporation  
5950 Symphony Woods Suite 510  
Columbia, MD 21044**

## CONSENT TO SHARE DATA

As an applicant to the Medicare Care Management Performance Demonstration project I agree to comply with the requirements of this demonstration including sharing all data submitted to the Quality Improvement Organization or CMS with CMS and/or its contractors assisting in the implementation or evaluation of the demonstration.

This consent is subject to any restrictions imposed by any applicable law if gathered or viewed by a QIO operating under its contract with CMS under Part B of the title XI of the Social Security Act, CMS, or the contractor engaged by CMS under §649(d) of the MMA to perform administrative tasks for the demonstration project as described in that provision.

|   |      |
|---|------|
| Provider Name ( <i>print</i> )          |      |
| Provider Signature                      |      |
| Medicare Provider Identification Number | Date |