QIES (MDS/PBJ) Third-Party Service Bureau User Request

This form must be completed by a facility in order to:

1. **Designate a third-party service bureau user** to submit assessments and/or staffing information on the facility's behalf
2. **Remove access** of a current third-party service bureau user to the facility in situations such as termination or turnover

A Third-Party Service Bureau is defined as follows: An outside entity contracted by the facility or a corporation to provide services. The entity is typically contracted to process submissions, but may also be contracted to retrieve and/or review report data for facilities. The entity is not limited to contracting with facilities in a single state and may provide services for facilities in multiple states.

Warning: Security regulations do not allow a user ID to be logged on to multiple sessions simultaneously. Problems may arise if the third-party service bureau user ID is used with an automated submission system and accesses multiple servers.

NOTE: For a state license-only facility, please provide the Facility ID used for submissions in lieu of the Medicare CCN.

Please complete this form, in its entirety, electronically

Note: *In order to e-mail this form, you must first save it as a text file.* Instructions for downloading and saving PDF forms are available at https://qtso.cms.gov/access-forms/data-access-request-information.

Type of Request (REQUIRED)

Request to Create New Third Party Personal User ID for:

- ☐ MDS Submission
- ☑ Payroll Based Journal (PBJ)

Request to Change:

- ☑ Add Facility
- ☐ Remove Facility

Third Party User's Current Personal ID: 37P4S16167

Third-Party User Information (REQUIRED)

First & Last Name:	Tara Altenritter	User Phone:	8775219834
User E-mail Address:	tara@qies.simpleltc.com		
User Physical Address:	11100 Nall Ave Overland Park, KS 66211		
Company Name:	SimplePBJ		

Facility Information (REQUIRED)

(of the facility for which data will be submitted or reports requested)

Facility Name:			
Medicare CCN or Facility ID:		☐ Check if Facility is State License-Only (Medicaid Only)	
Facility Physical Address:			
Facility Mailing Address:			
Facility Contact Person Name:		Contact Person Phone:	
Contact Person Title:			
Contact Person E-mail Address:			
Request Date:			

Fax OR e-mail the completed form to the Help Desk

E-mail submissions must include facility letterhead as an attachment

E-mail: iqies@cms.hhs.gov

Fax cover sheet must contain facility letterhead and must come from a facility fax machine

Fax: 888-477-7871

After submitting the request, if you do not receive e-mail acknowledgment within 2 business days, please contact us immediately

Please allow 5 business days for your request to be completed