Data Restore Request

This form must be completed by the provider.

To ensure your information can be clearly read, please complete this form electronically before printing.

The administrator or owner must sign the hard copy.

Fax the completed and signed form to the state for verification. Fax to 850-414-6946

Provider Information

Contact Name: (Owner or Administrator)
(First Name, Middle Initial, Last Name)

E-mail Address:

Provider Name:

Provider Address:

Phone Number: Extension:

Facility/Provider ID Numbers

Facility ID or Facility Internal ID: (Can be found on your validation report)

CCN: (Also called Provider Number, Medicare Number, OSCAR Number, or Certification Number)

Data Request Specifics

Submission Date Range of the Missing Data: From: To:

Approximate Number of Assessments Done in That Time Period:

Software Used to Encode Data:

Was Information Lost Due to a Security Breach? Yes ◯ No ◯

Why Is the Data Being Requested? (Provide Details):

Future Backup Plans

Please indicate how you plan to back-up your data in the future to protect it from loss:

Name and Signature of Administrator or Owner Requesting the Data

Admin or Owner's Name:

Authorizer Signature: (sign in black or blue ink)

Contact Phone Number: Ext:

Date:

Name and Signature of State MDS/OASIS Automation Coordinator

State Authorizer Name:

State Authorizer Signature: (sign in black or blue ink)

State Authorizer Phone: Ext:

Date:

State Authorizer E-mail Address:

CMS will e-mail an invoice for $270 to the provider indicated above. This invoice must be paid before CMS will process and release the data. No data can be e-mailed. CMS will ship the CD by regular US mail unless the requestor provides an express carrier (FedEx, DHL, Airborne, or UPS) account number. For express delivery, please indicate the account number below.

If no number is provided, the CD will be sent by regular mail.

Express Carrier Account Number: (If blank, CD will be sent by regular mail)