



Hospital Contact Form

All information must be complete for processing

NOTICE: It is important to notify eQHealth Solutions immediately when contacts change

(12-DIGIT PROVIDER ID REQ'D)												
Hospital Name:												
Hospital Address:												
City, State & Zip:												

Send completed form to:
 eQHealth Solutions
 Attn: Provider Education & Outreach
 Fax: (630) 317- 5101

ONLY FILL IN THE CONTACTS YOU WANT US TO UPDATE:

Position/Contact Type	Full Name	Prof. Suffix	Title	Mailing Address (if different from above)	Email Address	Telephone & Fax
Hospital CEO or CFO						T: F:
Hospital Medical Director						T: F:
Hospital-assigned eQHealth Liaison						T: F:
Hospital-assigned Quality Contact						T: F:
Hospital-assigned Web Administrator						T: F:
2 nd Web Administrator						T: F:
Retro Chart Contact						T: F:

Hospital CEO or CFO Signature
 (MUST be signed for eQHealth Liaison change)

eQHealth Liaison Signature
 (Required for Web Administrator or Quality Contact)

Date