HEDIS® Medicare Health Outcomes Survey Request for Use of the Questionnaire

Overview

The Medicare Health Outcomes Survey (HOS) is the first HEDIS®[1] outcome measure for Medicare beneficiaries. The goal of the Medicare HOS program is to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health. The following Medicare HOS Instruments are available for use with permission (please see below for instructions to request for use of the questionnaire):

- Medicare Health Outcomes Survey Instrument Version 2.0
- Medicare Health Outcomes Survey Instrument Version 1.0

Copies of the HOS 2.0 and 1.0 questionnaires are available for download from the Survey Instrument section of the HOS web site at www.hosonline.org/surveys/hos/hosinstrument.asp. For copies of the HOS-Modified questionnaire or other languages (Spanish, Chinese) please contact NCQA at HOS@ncqa.org.

Instructions to Request Use of the Questionnaire

1. **Survey Use Form:** Complete and sign the HEDIS® Medicare Health Outcomes Survey Use Form to request to use the questionnaire.

2. **Survey Instrument:** Provide a sample copy of the proposed questionnaire including the appropriate copyright for the Medicare Health Outcomes Survey and/or the results attributed to the Medicare Health Outcomes Survey as indicated on the inside front cover of the Medicare Health Outcomes Survey questionnaires.

3. **Submit Survey Use Form and Proposed Survey Instrument To:**
   Tony Yep
   Medicare Health Outcomes Survey Project Manager
   NCQA
   1100 13th St NW, Suite 1000
   Washington DC 20005
   HOS@ncqa.org

   All requests are subject to approval by NCQA and CMS. Notification will be sent via e-mail within 10 business days.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

HEDIS® Medicare Health Outcomes Survey Use Form

1. ORGANIZATION/CONTACT INFORMATION		
1a. ORGANIZATION NAME		
1b. MEDICARE CONTRACT NUMBER (if applicable)		
1c. PRIMARY CONTACT PERSON		
FIRST NAME	MIDDLE INITIAL	LAST NAME
1d. TITLE	1e. DEGREE (e.g., RN, MD, PhD)	
1f. MAILING ADDRESS I		
1g. MAILING ADDRESS 2		
1h. CITY	1i. STATE	1j. ZIP CODE
1k. TELEPHONE AND FAX *(Area code, number and extension)*		1l. E-MAIL ADDRESS
TEL:	FAX:	
1m. ORGANIZATION TYPE ☐ HMO ☐ PPO ☐ Disease Management	☐ Academic Institution ☐ Government (Specify Agency) ______________	☐ Other (Specify) ______________

2. PROJECT INFORMATION		
2a. PROJECT TITLE		
2b. PROJECT TYPE ☐ Quality Improvement ☐ Clinical Projects	☐ Research	☐ Other (Specify) ______________
2c. PROJECT TIMING		
Project Start Date:	Project End Date:	
2d. PROJECT DESCRIPTION (Briefly describe the purpose of project, population you will be surveying and the analyses to be conducted; attach additional sheets, if necessary)		

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3. QUESTIONNAIRE INFORMATION (Include Sample Questionnaire with Form)
3a. Version of HOS Questionnaire Requested:
3b. Items Used in Questionnaire ☐ Complete Questionnaire ☐ Subset of Questionnaire (Specify Survey Questions) ____________________

4. APPLICANT ORGANIZATION SUBMISSION	
Please complete and date the form. I hereby attest that the information contained in this form is accurate to the best of my knowledge, and I agree that the Medicare Health Outcomes Survey will be used solely for the purpose specified in this Survey Use Form. **Authorized Representative**	
Name:	
Title:	
Organization:	
Date:	

FOR QUESTIONS AND FORM AND SAMPLE QUESTIONNAIRE SUBMISSIONS, SEND TO:

Tony Yep
Medicare Health Outcomes Survey Project Manager
NCQA
1100 13th St NW, Suite 1000
Washington DC 20005
HOS@ncqa.org

TO BE COMPETED BY NCQA HOS STAFF	
Documentation Provided: ☐ Survey Use Form ☐ Sample Questionnaire	Request approval: ☐ Yes ☐ No
Comments:	
Reviewer Name:	
Title:	
Date:	

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