



## Medical Record Retrieval Survey

This survey includes questions about the appropriate point of contact and your practice's medical recordkeeping process. Your responses will ensure efficient and accurate collection of medical records.

**Please return this survey via email to:** [vulaganathan@cfhp.com](mailto:vulaganathan@cfhp.com) or [gsenthilkumar@cfhp.com](mailto:gsenthilkumar@cfhp.com).

*If you have questions, please contact Community First Department of Quality Management at 210-510-2464 or 210-358-6486.*

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### HEDIS® Point of Contact

*Please list the point persons with whom to coordinate medical record retrieval. These individuals should be able to provide assistance during retrieval.*

Primary Point of Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Preferred Method of Contact: Phone    Email    Fax

Office Hours: \_\_\_\_\_

Secondary Point of Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Preferred Method of Contact: Phone    Email    Fax

Office Hours: \_\_\_\_\_

### Office Location

Office Group Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

1. Have any providers or office locations recently merged or been acquired by your office?: Yes    No

If yes, please explain:

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2. Please list the names of Providers who practice in your office location.

3. Do the Providers listed above share medical records? Yes No

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### Medical Records

1. Are your office's medical records EMR or paper? EMR Paper
  2. For EMR, can Community First use a USB device to copy records from your EMR system? Yes No
  3. For EMR, can Community First print records from your EMR system? Yes No
  4. For EMR, how far back does your EMR go?
  5. Does Community First need a password set prior to access systems? Yes No
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### Multiple Office Locations

*Please only complete this section if your office has more than one physical location.*

1. Are your medical records shared between locations? Yes No
2. If yes, are the records accessible from one location? Yes No
3. If yes, please list the office location at which records can be accessed:

Address:

City: State: Zip:

Phone Number:

4. If records are not shared and/or not accessible from one location, please list all locations:

Office Group Name:

Address:

City: State: Zip:

Phone Number:



## Medical Record Retrieval Survey

Office Group Name:

Address:

City:

State:

Zip:

Phone Number:

Office Group Name:

Address:

City:

State:

Zip:

Phone Number:

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### Third Party Vendors

*Please complete this section if your office uses third party vendors for medical record retrieval.*

1. Does your office use third party vendors for medical record retrieval? Yes    No
2. Should we contact the vendor directly for retrievals? Yes    No
3. If yes, provide the vendor's contact information.

Vendor Name:

Phone Number:

Email:

Fax: