



COMPANY INFORMATION

Date of Application: (MM/DD/YY)

Organization Name:

Street Address: City: State: Zip:

Primary Contact Name:

Phone Number: Email:

Number of individual locations you anticipate enrolling in benchmarking:

BENCHMARKING PROGRAMS AVAILABLE (check all that apply)

Patient Satisfaction

1. Have you adopted the NHIF Uniform Patient Satisfaction Survey Questions for Home Infusion Providers?
 Yes If yes, date you began with the survey:
 No If no, date you anticipate beginning to use the NHIF survey:
2. Do you currently utilize a third-party to administer patient satisfaction surveys?
 Yes Name of third-party administrator:
 No
3. Do you offer patients the option to receive a paper survey? Yes No
4. Do you currently survey patients at the time of discharge? Yes No
5. Will you submit survey data from active, long-term patients? Yes No

Status at Discharge (Required for participation in all other metrics *not including Pt Satisfaction)

- Adopted the NHIF Standardized Therapy Categories
- Adopted the NHIF Definitions for Patient Outcome Data Elements
- Adopted the NHIF Standardized List of Access Devices

30 Day Re-hospitalization

- Adopted the NHIF Standardized Therapy Categories
- Adopted the NHIF Definitions for Patient Outcome Data Elements
- Adopted the NHIF Standardized List of Access Devices

NHIA MEMBERSHIP

NHIA Member? Yes Enter NHIA Member Number of Primary Contact:

No Check here if you are interested in learning about becoming an NHIA member.

Submit this form to NHIF at NHIFdata@nhia.org.

NHIF Internal Use

Date Received:

Forwarded to: Benchmarking Membership

Date Responded:

Enrolled: Yes No Pending Comments: