

THE SOCIETY OF THORACIC SURGEONS NATIONAL DATABASE

Data Sharing Consent and Release Form 2019 Merit-Based Incentive Payment System STS National Database

I, the undersigned, hereby give permission to The Society of Thoracic Surgeons ("STS") and the Duke Clinical Research Institute ("DCRI") to transmit to the Centers for Medicare and Medicaid Services ("CMS") certain data previously submitted to the STS National Database in accordance with the STS National Database Participation Agreement upon which my name appears within Schedule A thereto, in order to provide performance data on cardiac and/or general thoracic surgery measures and demographic information as required by CMS for purposes of my participation in the CMS Merit-Based Incentive Payment System ("MIPS") program.

I understand that only by signing this Consent/Release Form will STS and DCRI be authorized to submit data on my behalf to CMS for the MIPS program.

I understand that CMS requires that my Merit-Based Incentive Payment System data be submitted under my National Provider Identifier ("NPI") as well as the Taxpayer Identification Number ("TIN") of the Taxpayer holder of record for my NPI, and I consent to the release of these identifiers to CMS in conjunction with my Merit-Based Incentive Payment System data. **I hereby attest that the NPI and TIN (used for claims submission for physician services) that have been submitted to the STS National Database by me or on my behalf are correct.**

I understand that CMS plans to publish select 2019 Merit-Based Incentive Payment System measures on the "Physician Compare" website in 2020, and that by executing this Consent/Release Form, I am consenting to the possible public reporting of my data.

I agree to hold STS, DCRI and their representatives harmless in connection with their actions taken in good faith reliance on this Consent/Release Form.

I represent and warrant that I have the full right and authority to act in this matter as set forth above.

I authorize STS to accept this signed form via hard copy or email as hard copy originals.

_____ STS National Database Participant ID#(s)	_____ Surgeon Name (print)
_____ Surgeon Street Address	_____ Surgeon NPI# (<u>required</u> - unique provider ID number)
_____ Surgeon Email Address (<u>required</u>)	_____ TIN (s) (<u>required</u> -enter all Tax ID numbers used by this provider to bill Medicare Fee For Service)
_____ Surgeon Signature (<u>required</u>)	_____ Date

Send completed form to STS

Email: QRPS@sts.org

Mail: The Society of Thoracic Surgeons Attn: QRPS 633 N. St Clair Street, Suite 2100, Chicago, IL 60611-3658