

Maryland Medicaid Data Request

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| **1. Date of Form Submission** |   |
| **2. Project Title**  |  |
| **3. Principal Investigator’s** |  |
|  Name: |  |
|  Position Title: |  |
|  Organization: |  |
|  Street Address: |  |
|  City, State, ZIP Code: |  |
|  Email Address: |  |
|  Telephone #: |  |
|  Facsimile #: |  |
| **4. Type of Data Request** |
| ❑ First-Time Data Request |
| ❑ Expanded Data Request Using Previously Acquired Data (Indicate Previous Study Title & MDH IRB Protocol #) |
| ❑ Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **5. Purpose of Data Request**  |
| **□** Research □ Program Administration □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **6. Periodicity of Data Request**  |
| □ Monthly □ Quarterly □ Semi-Annually □ Annually □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **7. Research Proposal** |
| Study’s Central Aim, Goals, Objectives: |
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| Study’s Central Aim, Goals, Objectives (Continued): |
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| **8. Population of Interest**  |
| ❑ Providers ❑ Enrollees ❑ Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **9. Deliverables Requested**  |
| ❑ Service-level Data Sets (Raw Fee-For-Service Claims and/or Managed Care Encounters)❑ Person-level Data Sets (Summarized by Enrollee)❑ Provider-level Data Sets (Summarized by Provider)❑ Frequency Tables (e.g. Aggregate Counts of Visits, Enrollees, or Services Used By Characteristics Of Interest) |
| ❑ Health Choice Managed Care Organization Encounter Data□ Inpatient□ Outpatient□ Physician□ Special Services□ Home Health□ Pharmacy□ Long-term Care□ Dental□ Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ❑ Fee-for-Service Claims Data□ Inpatient□ Outpatient□ Physician□ Special Services□ Home Health□ Pharmacy□ Long-term Care□ Dental□ Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ❑ Primary Adult Care (PAC) Program Encounter Data (Note: PAC Program was discontinued 12/31/13)□ Outpatient□ Physician□ Special Services□ Pharmacy❑ Demographic Data❑ Enrollment Data ❑ Non-MMIS Data or External Files (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❑ Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Time Period of Needed Data:❑ State Fiscal Year (7/1 – 6/30) Year(s):❑ Calendar Year (1/1 – 12/31) Year(s):❑ Federal Fiscal Year (10/1 – 9/30) Year(s):❑ Specify Start and End Dates:  |
| Comments to Clarify Targeted Time Period: |
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| **For All Sections Below, Complete If Applicable To Your Request** |
| **12. Medicaid Beneficiary Population(s) To Be Studied** (e.g., All Medicaid Beneficiaries, Health Choice Managed Care Participants Only, …) |
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| **13. Targeted Beneficiary Characteristics** (e.g., Race, Age Group, Gender, County/Region, Coverage Group,  Length of Enrollment, Other Demographics...) |
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| **14. Targeted Diagnoses (If Any), Including List of Relevant ICD Diagnostic Codes**(When indicated, take into account the timing of the migration from ICD-9 to ICD-10 codes on 10.1.15. Also, indicate whether the targeted population should be identified using the primary diagnosis only, or any diagnosis field, i.e., primary or secondary diagnosis.) |
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| **15. Health & Related Services to Be Evaluated** (If Relevant, Include List of CPT, HCPCS, Revenue or Other Codes) |
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| **16. Cost Estimates** (Fee-For-Service Payments, Managed Care Capitation or Imputed Costs, Etc.) |
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| **17. Targeted Providers or Provider Types**  |
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| **18. Targeted Service Locations** (e.g., ZIP Code, County, Region) |
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| **19. Other Parameters of Needed Data Sample** (Provide whatever additional information may be needed by data provider to fulfill this data request) |
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| **20. Table Structure Needed** (If applicable, describe the table structure needed and/or insert example table shell) |
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| **21. Preferred Output File Format** (e.g. , SAS or Excel) **& Preferred Data Delivery Method**  |
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| **22. Additional Information** (e.g., Contact Information for Co-Investigator(s) and Study Coordinator, Other Data Specifications, Any Other Guidance for Data Provider) |
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