

Attachment G



Vermont Association Of Hospitals And Health Systems Discharge Data Transmittal Form

TO
HOSPITAL INDUSTRY DATA INSTITUTE
Attn: Vermont Data Collection Department
P.O. Box 60
4712 Country Club Drive
Jefferson City, MO 65109-4544
573/893-3700

FROM

Telephone # _____
Medicare Provider # _____

Name of person completing form: _____ E-mail: _____

Fill in the blank or circle the appropriate response

Type of Magnetic Media: 1/2" Tape Reel ZIP 100/250 3480/3490E Cartridge
5 1/4" Disk 3 1/2" Disk Other¹ _____

External ID # or Name: _____ **Record Length:** _____

File # or Name²: _____ **Block Size:** _____

Recording Density: 6250 1600

Coding Convention: EBCDIC ASCII

Data Format: VT Explor 1500 Other _____

Data Type: Inpatient Amburg/Outpatient Other _____

Submission Type: New Replacement Test

Discharge Period: From: _____ To: _____

Total Number of Discharges in File: _____ **Total Charges:** _____

Special Instructions: _____

¹Cost of conversion will be charged to the hospital (please call for details).
²If multiple files are included on a tape or disk, complete one transmittal form for each file.

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(For HID I Use Only)

Internal Tape Number: _____ Date Uploaded: _____
Date Received: _____ Date Returned: _____
Date Processed: _____ Data Set Name: _____