Optional Modified Initial Cover Letter for the HCAHPS Survey

[HOSPITAL LETTERHEAD]

[SAMPLED PATIENT NAME]
[ADDRESS]
[CITY, STATE ZIP]

Dear [SAMPLED PATIENT NAME]:

Our records show that you were recently a patient at **[NAME OF HOSPITAL]** and discharged on **[DATE OF DISCHARGE (mm/dd/yyyy)]**. Because you had a recent hospital stay, we are asking for your help.

The enclosed survey is part of an effort to understand how patients view their hospital care. Questions 1-29 in the survey are sponsored by the United States Department of Health and Human Services and should take about 7 minutes to complete.

Your participation is voluntary and your answers will be kept private. Hospital results are publicly reported on the Internet at www.medicare.gov/hospitalcompare to help consumers choose a hospital and help hospitals improve the care they provide.

After you have completed the survey, please return it in the pre-paid envelope. [*OPTIONAL*: You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.] If you have any questions about the enclosed survey, please call this toll-free number: 1-800-xxx-xxxx.

We greatly appreciate your help in improving hospital care.

Sincerely,

[HOSPITAL ADMINISTRATOR]
[HOSPITAL NAME]

[*OPTIONAL*: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0981. (Expires November 30, 2021). The time required to complete this information collected is estimated to average 7 minutes for questions 1-29 on the survey, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, C1-25-05, Baltimore, MD 21244-1850.]

Optional Modified Follow-up Cover Letter for the HCAHPS Survey

[HOSPITAL LETTERHEAD]

[SAMPLED PATIENT NAME]
[ADDRESS]
[CITY, STATE ZIP]

Dear [SAMPLED PATIENT NAME]:

Our records show that you were recently a patient at **[NAME OF HOSPITAL]** and discharged on **[DATE OF DISCHARGE (mm/dd/yyyy)]**. Approximately three weeks ago we sent you a survey regarding your hospitalization. If you have already returned the survey to us, please accept our thanks and disregard this letter. However, if you have not yet completed the survey, please take a few minutes and complete it now.

The enclosed survey is part of an effort to understand how patients view their hospital care. Questions 1-29 in the survey are sponsored by the United States Department of Health and Human Services and should take about 7 minutes to complete.

Your participation is voluntary and your answers will be kept private. Hospital results are publicly reported on the Internet at www.medicare.gov/hospitalcompare to help consumers choose a hospital and help hospitals improve the care they provide.

After you have completed the survey, please return it in the pre-paid envelope. [*OPTIONAL*: You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.] If you have any questions about the enclosed survey, please call this toll-free number: 1-800-xxx-xxxx.

We greatly appreciate your help in improving hospital care.

Sincerely,

[HOSPITAL ADMINISTRATOR]
[HOSPITAL NAME]

[*OPTIONAL*: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0981. (Expires November 30, 2021). The time required to complete this information collected is estimated to average 7 minutes for questions 1-29 on the survey, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, C1-25-05, Baltimore, MD 21244-1850.]