Attachment II-B

2016 CAHPS Survey Participation Form

(Please submit one form per plan and indicate each FEHB Sub-Code that is sharing data)

Plan Name: Click here to enter text.

FEHB Sub-Code(s): Click here to enter text.

Indicate which sub-codes share data: Click here to enter text.

Please check the appropriate box(es) below:

☐ Health Plan will conduct the CAHPS® 5.0H Adult Commercial Survey

☐ Health Plan is new to FEHB Program for 2016 and is not required to conduct CAHPS® Surveys in 2016

Name of NCQA Certified Survey Vendor that will be conducting the survey (s):
Click here to enter text.

Survey Vendor Contact Information:

Name: Click here to enter text.
Address: Click here to enter text.
Email: Click here to enter text.
Telephone Number: Click here to enter text.

Health Plan Contact for CAHPS:

Name: Click here to enter text.
Address: Click here to enter text.
Email: Click here to enter text.
Telephone Number: Click here to enter text.

Plan Contact & Address for Invoice (if different from above):

Name: Click here to enter text.
Address: Click here to enter text.
Email: Click here to enter text.
Telephone Number: Click here to enter text.

Please e-mail the completed form by **February 1, 2016** to: cahps@opm.gov