Data Extract Request Form

Instructions: Please complete all fields below and submit this form to initiate your data extract request.

Requestor Information

Name: ________________________________ **Date:** ________________

Company/Organization: ____

Email Address: ____

Phone Number: ____

Request Details

Explanation of Request: Please provide a detailed description of the data needed, including purpose and scope.

Frequency of Run: ☐ One-time ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other: ____________

Preferred Run Schedule: Month: ________________ Day of Month: ________________

Data Request and Attestation (DRA) Information

DRA Number: ____

Additional Users

List all individuals who will have access to this data extract:

Name	Title	Organization	Email

Approval

Requestor Signature: ________________________ **Date:** ____________

By submitting this data extract request, the requestor acknowledges and agrees that all CMS data is subject to controlled access and disclosure requirements under federal law, including the Privacy Act of 1974, HIPAA, and FISMA, and may only be used for the specific purposes outlined in the approved Data Use Agreement (DUA) and this request. The requestor agrees that CMS data shall not be shared, disclosed, or transferred to any third party without explicit written authorization from CMS, and access is restricted to individuals specifically named in the DRA and this request form. All data use is subject to CMS fraud prevention systems and monitoring protocols, and any suspected fraudulent activity or data misuse must be immediately reported to CMS, with the understanding that unauthorized use, disclosure, or misuse may result in civil and criminal penalties under federal law, including the Computer Fraud & Abuse Act of 1986. The requestor must maintain appropriate administrative, physical, and technical safeguards to protect CMS data, store, transmit, and process data in accordance with CMS security standards and DRA requirements, and upon completion of the authorized use period or termination of the DRA, return or securely destroy all CMS data as specified in the agreement. By signing, the requestor certifies they have read and understand all applicable CMS data use policies and legal requirements, will comply with all terms and conditions of the DRA, will ensure all authorized users are aware of and comply with these restrictions, and understand that violations may result in termination of data access and legal action. Violation of these terms may result in immediate termination of data access privileges and referral to appropriate law enforcement agencies. For questions regarding data use compliance, contact Data Architecture & Engineering Services at CMSDataadmin@cms.hhs.gov or the Office of Enterprise Data and Analytics at CMS_EnterpriseArchitecture@cms.hhs.gov.

For Office Use Only: Request ID: ____________ Assigned to: ____________ Date Received: ____________

Delivery Method:

Notes: