Louisiana Department of Health & Hospitals
Office of the Secretary
Louisiana Hospital Inpatient Discharge Database (LAHIDD)

HOSPITAL REGISTRATION FOR LAHIDD DATA SUBMITTAL

(To be Completed by Hospital)

Full Name of Hospital: _____

Primary Contact Name: _____
Address: _____
Telephone Number: _____ Fax Number: _____
E-Mail Address: _____

Primary Contact Name: _____
Address: _____
Telephone Number: _____ Fax Number: _____
E-Mail Address: _____

Method through which your facility will submit LAHIDD data (Check only one):

_____ **Directly to DHH through secure, Internet-based server**
_____ **Designate an intermediary**

If designating an intermediary, please complete the following:

Name of Intermediary: _____
Contact Name: _____
Address: _____
Telephone Number: _____ Fax Number: _____
E-Mail Address: _____

_____ _____
Signature of Hospital Representative Date

For LAHIDD Use Only
Received and Acknowledged:

_____ _____
Erin Proven, LAHIDD Manager *Date*

Send the completed form to:

Erin Proven, LAHIDD Manager
OPH Bureau of Health Informatics
Louisiana Department of Health
P.O. Box 629, Bin #4
Baton Rouge, LA 70821-0629
or
erin.proven@la.gov