Virginia All Payer Claims Database (APCD) Data Subscriber Report Application

I. Name: _____

II. Organization: _____ (the "Subscriber")

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email: _____

Check as Applicable: Government ☐ Business ☐ Non-Profit Business ☐ University ☐

Other: _____

II. State the reason(s) the report is requested.

III. Describe how and by whom the report will be utilized. If further distributed, to whom.

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Signature: _____ Date: _____

VHI Representative Signature: _____ Date: _____

Please email signed application
to: Nicole Sidrak
Virginia Health Information

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