Quarterly Attestation/Agreement

Submission Quarter & Year: ________ ______________________________

Member Name and Contact Information:

Member CIN# ______________________________

Date of Birth: ______________________________

Member Name: ______________________________

Is Member Durably Suppressed? (Suppressed $\geq$ 12 Months): ☐ YES ☐ NO

Date of Member's Most Recent VL Lab (mm/dd/yyyy): ______________________________

Member's Most Recent Lab Value (copies/ml): ______________________________

Has Member Received Supportive Services For The Quarter? ______________________________

Provider Information

HIV PCP Name: ______________________________

Provider Site Name: ______________________________

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Provider Attestation

I, ____, hereby attest that the medical data entry for reporting period ____________, ____________ accurately reflects information that I received in my capacity as ___________________________ when I treated the listed Medicaid beneficiary.

I do hereby attest that the following listed Medicaid patient is not enrolled or receiving financial incentives for another viral load suppression program. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Provider Signature

Provider's Signature

Date of Signature