



# Live Your Life . . . Undetectable!

Viral Load Suppression Incentive Program

## Quarterly Attestation

**Submission Quarter & Year:** \_\_\_\_\_

### Member Name and Contact Information:

Member CIN# \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Member Name: \_\_\_\_\_

Is Member Durably Suppressed?:  YES  NO

Date of Member's Most Recent VL Lab: \_\_\_\_\_

Member's Most Recent Lab Value: \_\_\_\_\_

Has Member Received Supportive Services For The Quarter? \_\_\_\_\_

### Provider Information

HIV PCP Name: \_\_\_\_\_

Provider Site Name: \_\_\_\_\_



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### Provider Attestation

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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

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Date of Signature

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