Quarterly Attestation/Agreement

Submission Quarter & Year: _____ _____

Member Name and Contact Information:

Member CIN# _____

Date of Birth: _____

Member Name: _____

Is Member Durably Suppressed? (Suppressed ≥ 12 Months): ☐ YES ☐ NO

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

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

Provider Information

HIV PCP Name: _____

Provider Site Name: _____

Quarterly Attestation/Agreement

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