AMIDA CARE HEALTH. ADVOCACY. CARE.

Primary Care Provider's Attestation Verifying HIV Status

Note: PCP attesting must be the treating practitioner.

Patient Name (Please print clearly): ____
Last Name First Name

DOB: ______________________________ Medicaid #: ______________________

1. Attach laboratory test(s) with undetectable VL that have clear date(s).

2. List current ARV's you, the treating PCP, have prescribed:

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3. How long patient has been with you, the treating PCP? Specify dates.

from__________________ to ________________.

4. How was HIV status determined by you, the treating PCP, without confirmatory laboratory data? Please specify.

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NOTE: ☐ Please check box if patient is HIV negative.

Name of treating PCP (Please print clearly): ____
Last Name First Name

License number: ___________________________________

Practice site: ____

Telephone number:_________________________________

Signature of treating PCP: __________________________________ Date:______________________

14 Penn Plaza, 2nd Floor
New York, NY 10122
T 646-757-7000
F 646-786-1802