Provider ID Group #: _____

Primary Coverage Member ID: _____

Secondary Coverage Member ID: _____

I am a recipient of Medical Assistance, I certify that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements or documents, or concealment of material information may be prosecuted under applicable Federal and State laws.

_____ _____ _____

Signature of Patient (Authorized Individual) Date Time

_____ _____

Printed Name of Patient or Authorized Individual Relationship to Patient

If signed by Authorized Individual, reason not patient's signature:

❒ Incompetent ❒ Unconscious ❒ A Minor ❒ Other _____

MEDICAL ASSISTANCE VERIFICATION

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