GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

Puerto Rico Medicaid Program

Out-of-State Emergency Service Attestation Form

Provider Name		Provider NPI #	
Address Line 1 *(Street Name and Number)*		**Address Line 2** *(Suite, Room, etc.)*	
City		**State**	**Zip Code+4**
Date of Service – From *(Use date format MM/DD/YYYY)*		**Date of Service – To** *(Use date format MM/DD/YYYY)*	

By my signature below I attest that I provided emergency medical service(s) to a Puerto Rico Medicaid Program member during the dates listed above.

Signature: _____ Date: _____

Printed Name: _____

This form must be signed by the rendering provider. In the case of an organizational provider, an authorized representative must sign.

Upload this form as an attachment to your enrollment application through the Provider Enrollment Portal (PEP). Do NOT attach Protected Health Information (PHI) to your application.