GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

Puerto Rico Medicaid Program

Out-of-State Prior Authorization Attestation Form

Provider Name		**Provider NPI #**	
Address Line 1 *(Street Name and Number)*		**Address Line 2** *(Suite, Room, etc.)*	
City		**State**	**Zip Code+4**
Prior Authorization #			
Prior Authorization Effective Date *(Use date format MM/DD/YYYY)*		**Prior Authorization End Date** *(Use date format MM/DD/YYYY)*	

By my signature below I attest that I have received prior authorization to provide medical service(s) to a Puerto Rico Medicaid Program member during the dates listed above.

Signature: _____ Date: _____

Printed Name: _____

Complete one form for each Prior Authorization.

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