

4. During the reporting period, I was absent from the practice for _____ days due to illness, vacation, or for continuing professional education.
5. For this reporting period:
 - a. Number of office visits (excluding phone consultations or hospital visits) _____
 - b. Number of visits from 5a who reside in a Health Professional Shortage Area _____
 - c. Number of hospital visits _____
 - d. Number of patient visits for whom a Medicare claim was submitted _____
 - e. Number of patient visits for whom a Medicaid claim was submitted _____
 - f. Number of patients wherein services were rendered at a rate less than usual customary fee _____
 - g. Number of patient visits for which no charge was made (per inability to pay) _____
6. My Medicare Provider Number is: _____
7. My Medicaid Provider Number is: _____

CERTIFICATION

I CERTIFY THAT THE ABOVE REPORTED INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND ACCURATELY REFLECTS ACTIVITIES TO THE FULFILLMENT OF MY OBLIGATION TO THE MONTANA J-1 VISA WAIVER PROGRAM.

Physician's Name: (Print or Type)

Physician's Signature Date

ENDORSEMENT

I HAVE REVIEWED THE ABOVE REPORT BEING SUBMITTED BY _____ WHO BEGAN HIS/HER PRACTICE WITH US ON _____. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IS ACCURATE AND CORRECT.

Organization: _____ Date: _____

Signature: _____ Title: _____

RETURN THIS FORM TO:
Indiana State Department of Health
Primary Care Office
2 North Meridian, 2J
Indianapolis, IN 46204