



Provider & Patient Attestation of Assessment

SAVE THIS FORM FOR YOUR VISIT

Member ID #: _____

PROVIDER

I attest that I saw the health plan member/patient identified on this form on the date listed below and performed a face-to-face personal health visit.

Printed First Name: _____ Printed Last Name: _____

NPI#: _____

Signature: _____ Date: _____

PATIENT/HEALTH PLAN MEMBER

I attest that the above named provider saw me today and performed a face-to-face personal health visit.

Printed First Name: _____ Printed Last Name: _____

Signature: _____ Date: _____

Provider Instruction:

Upon completion of form at visit, please mail the white copy to:

Inovalon Data Processing
1219 Chambersburg Road
Gettysburg, PA 17325



Provider & Patient Attestation of Assessment

Member ID #: _____

PROVIDER

I attest that I saw the health plan member/patient identified on this form on the date listed below and performed a face-to-face personal health visit.

Printed First Name: _____ Printed Last Name: _____

NPI#: _____

Signature: _____ Date: _____

PATIENT/HEALTH PLAN MEMBER

I attest that the above named provider saw me today and performed a face-to-face personal health visit.

Printed First Name: _____ Printed Last Name: _____

Signature: _____ Date: _____

Provider Instruction:

Upon completion of form at visit, please mail the white copy to:

Inovalon Data Processing
1219 Chambersburg Road
Gettysburg, PA 17325