PROMOTING INTEROPERABILITY PROGRAM

FACILITY ROSTER – GROUPS

I, (print Group Administrator's name) ____, administrator for the Group (print name) ____, certify that all the providers listed below have had at least one Medicaid encounter with this group or clinic during the year containing the 90-day representative period (previous calendar year or 12-month period prior to attestation). Providers authorized to use the EHR installed at this facility will have a check-mark under the column "Authorized to use EHR".

Administrator's Signature: ______________________________ Date: ____________________

Administrator's Phone: ______________________ Group NPI: __________________

CEHRT Name: ____________________________ Group TIN: ________________

CEHRT ONC EHR # _______________________

List of Providers under contract in the Group						
First Name	**Last Name**	**NPI**	**Specialty**	**Date joined the Group**	**License #**	**Authorized to use the EHR (Y/N)**

ASES
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

PROMOTING INTEROPERABILITY PROGRAM

List of Providers under contract in the Group						
First Name	**Last Name**	**NPI**	**Specialty**	**Date joined the Group**	**License #**	**Authorized to use the EHR (Y/N)**

For more information, visit the Puerto Rico State Level Registry (SLR) webpage at http://pr.arraincentive.com, call 787-474-3300 or send your inquiries to mppipr@asespr.org