DEPARTAMENTO DE SALUD
GOBIERNO DE PUERTO RICO

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)**

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