DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

ENCOUNTER FORM

PROVIDER NAME	PROVIDER NUMBER

ADDRESS

"My signature certifies that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws."

DATE	RECIPIENT NUMBER	RECIPIENT'S SIGNATURE I have read and agree with the above statement.