STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES FINANCING

****

PROVIDER DISCLOSURE – FEE FOR SERVICE (FFS)

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STATE OF LOUISIANA
PARISH OF _____

I hereby certify that I am the_____[title] and an authorized agent of _____[Physician Group/Dental Group].

I further certify that_____[Physician Group/Dental Group] is not making a donation to any public entity, including, but not limited to, a public hospital or public government that is later used for an intergovernmental transfer to the Louisiana Department of Health.

_____ _____

Witness [Name]
[Title]
[Physician/Dental Group]

_____

Witness

SWORN AND SUBSCRIBED BEFORE ME, the undersigned Notary Public, on this_____day of _____, Year_____, at_____, Louisiana.

_____

Notary Public