# *PHYSICIAN'S ACKNOWLEDGMENT STATEMENT MONITORING*

**HOSPITAL NAME: _____ PROVIDER/NPI NUMBER: _____ DATE: _____**

**CONTACT PERSON: _____CONTACT PHONE NUMBER:_____**

| *Physician's Name* | *UPIN/NPI #* | *Date Admitting Privileges Granted* | *Date Acknowledgment Signed* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please return this completed form to** Quality Insights of Pennsylvania, Attn: Case Review at fax number 717.671.5970 or mailing address 2601 Market Place Street, Suite 320, Harrisburg, PA 17110

Submitted by (signature): _____ Date: _____

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization for Pennsylvania, under contract with the Centers for Medicare & Medicaid Services (CMS). The views presented do not necessarily reflect those of CMS. Publication number 9SOW-PA-BEPR08.2 App: 9/08