

**1020 - ATTACHMENT A – INPATIENT HOSPITAL SHOWINGS
REPORT ATTESTATION FORM**

HEALTH PLAN NAME: _____

REPORTING PERIOD: _____
START OF PERIOD *END OF PERIOD*

I hereby certify that during the specified period on this Form, for each AHCCCS member, whom federal financial participation was claimed, there were methods and procedures with the Contractor to assure that:

- A. A physician certified (and, where inpatient hospital services were furnished over a period of time, recertified) the necessity of inpatient hospital services for each AHCCCS member receiving such services as mandated by Section 1903(g)(1) and Section 1903(g)(6) of the Social Security Act.
- B. In the case of each AHCCCS Member receiving inpatient hospital services, such services were furnished under a contract plan physician, as mandated by Section 1903(g)(1) of the Social Security Act.
- C. There was in operation a continuous program of utilization review under which the admission of each AHCCCS member receiving inpatient hospital services was reviewed or screened in accordance with Section 1903(g)(1) of the Social Security Act.

SIGNATURE OF MEDICAL DIRECTOR *DATE*

PRINTED NAME OF MEDICAL DIRECTOR