ENCOUNTER FORM

Provider Name _____ MA ID Number _____

Address _____

"I certify that I am actively involved in receiving Targeted Case Management Services. I understand that payment and satisfaction of claims will be from public funds (federal, state and local), and that any false claims, statements or documents, or concealment of material facts, may be prosecuted under applicable laws."

DATE	CASE NUMBER	RECIPIENTS SIGNATURE I HAVE READ AND AGREE WITH THE ABOVE STATEMENT