

LOUISIANA CONRAD STATE 30 PROGRAM FLEX (NON-HPSA) SUPPORT REQUEST

Name and Address of Practice Site:	Name and Address of Employer (if different):
Contact Name and Title:	Practice Site Telephone Number:
E-mail:	Practice Site Fax Number:
Telephone:	Employer Telephone Number:
Fax:	Employer Fax Number:
FOR SERVICES RENDERED FROM: _____ TO: _____	
(MM/YY) (MM/YY)	
Patient Profile Statistics: Complete each item and indicate ACTUAL or ESTIMATED FOR THE TOTAL PRACTICE NUMBERS (write an E if estimated).	
# of total patients/# of visits: /	# Primary Care patients/# of visits: /
# Specialty Care patients/# of visits: /	# AIDS/HIV (if pertinent to approval)/visits: /
# Medicaid patients/# of encounters: /	# Medicare patients/# of encounters: /
# Uninsured/underinsured self pay (non-indigent) patients/# of visits: /	# Uninsured/underinsured indigent SFS patients/# of visits: /
# of total HPSA residents treated/# of visits: /	
Which HPSAs are served? (Patient Zip Codes and HPSA ID # of that area, e.g. 70131—HPSA #122071)	
# of Medicaid patients from HPSAs/# of visits: /	# of Medicare patients from HPSAs/# of visits: /
# Uninsured/underinsured self pay (non-indigent) HPSA patients/# of visits: /	# Uninsured/underinsured indigent SFS patients/# of visits: /
<i>By signing below, I verify that the information provided in this for this facility/medical practice is correct for the period noted on this form.</i>	
CEO/Administrator's Signature/Title:	Office Manager/Form Compiler's Signature/Title:
Date:	Date: