PHYSICIAN ACKNOWLEDGMENT MONITORING FORM
For Calendar Year _____
(Copies of form may be made as needed)

Hospital Name: _____
Hospital Provider Number: _____
Name of Hospital Contact: _____
Phone Number for Hospital Contact: _____
Email Address for Hospital Contact: _____

Physician Name	NPI	Date physician granted admission privileges	Date physician acknowledgement signed	Date 1st Medicare facility claim submitted for this physician

This report to MPRO is an annual requirement.
Fax or mail completed form to MPRO by April 1st each year for the previous calendar year physician acknowledgements.
Please include a photocopy of each signed Physician Acknowledgement Statement.
Fax to 248-465-7428, attention Medicare Review.