

ALABAMA NATIONAL INTEREST WAIVER PHYSICIAN PRACTICE STATUS REPORT

Revised July 2014 (Previous editions are obsolete and should not be used)

Applicable to Physicians With Approved NIW Visa Waivers

This report is to be completed by each physician approved under Alabama's National Interest Waiver Program. This report must be completed when the physician first starts work under his/her NIW and each 6 months thereafter, until the physician completes his/her waiver service obligation. If the physician is currently under J-1 waiver service at the same location, continued reporting on the usual 6 month reporting cycle is acceptable, except that this NIW report form must be used during the NIW service period.

Please type or print all entries except signatures.

PART 1 - TO BE COMPLETED BY REPORTING PHYSICIAN:

Physician's Name: _____
(First Name) (Middle Initial) (Last Name)

Type Service (Circle One): Primary Care Clinical Practice Primary Care Emergency Department
Psychiatrist Sub-specialist in _____

During this report period, I have practiced medicine at a total of _____ practice sites, as named below.

Practice Site(s): _____
(Practice Site(s) Name)
Practice Address(es) _____
During Report (Street)
Period: (If additional _____
practice sites, list on _____
separate sheet of paper) (City) (County) (State) (Zip Code)
Practice Telephone #(s): _____ - _____ - _____ Email Address: _____

Report Number (circle one):

Initial Report: I began practicing at this location(s) on (insert date): _____
6 Month Report: I have been practicing at above location(s) for 6 months, from _____ to _____
7 - 12 Month Report: I have been practicing at above location(s) for 7-12 months, from _____ to _____
13 -18 Month Report: I have been practicing at above location(s) for 13-18 months, from _____ to _____
19 - 24 Month Report: I have been practicing at above location(s) for 19-24 months, from _____ to _____
25 - 30 Month Report: I have been practicing at above location(s) for 25-30 months, from _____ to _____
31 - 36 Month Report: I have been practicing at above location(s) for 31-36 months, from _____ to _____
37 - 42 Month Report: I have been practicing at above location(s) for 37-42 months, from _____ to _____
43 - 48 Month Report: I have been practicing at above location(s) for 43-48 months, from _____ to _____
49 - 54 Month Report: I have been practicing at above location(s) for 49-54 months, from _____ to _____
Final Report: I have completed 55-60 months service at above location(s), from _____ to _____, and:
55 - 60 Months
_____ I intend to remain at this location
_____ I do not intend to remain at this location

My typical work schedule during this reporting period has been as follows: (Example of entry: From 8 AM to 5 PM, less 1 hour for meal break = 8 actual work hours.)

Monday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours
Tuesday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours
Wednesday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours
Thursday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours
Friday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours
Saturday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours
Sunday: From _____ to _____ less _____ hour meal break = _____ actual in-clinic work hours

Total Hours Worked Each Week: _____

(Continued on reverse)

PART 1 - CONTINUED

The number of patients I have treated during this reporting period were as follows:

	<u>Number</u>	<u>Percentage</u>
a. Total number of patient visits (Sub-specialists should include all visits, but primary care physicians should not include telephone consultations or hospital visits)	_____	100 %
b. Number of patient visits for whom a <i>Medicare</i> claim was submitted:	_____	_____ %
c. Number of patient visits for whom a <i>Medicaid</i> claim was submitted:	_____	_____ %
d. Number of patient visits wherein services were rendered at a rate less than the usual and customary fee under a sliding fee scale:	_____	_____ %
e. Number of patient visits for which no charge was made (based on inability to pay):	_____	_____ %
f. Number of patient visits covered by private insurance:	_____	_____ %
g. Number of uninsured, self-pay visits who paid full charges:	_____	_____ %
h. Number of patients who did not pay and inability to make further contact with patients	_____	_____ %

My *Medicare* Provider Number(s) is (are): _____

My *Medicaid* Provider Number(s) is (are): _____

Number of Alabama Medicaid Patient 1st participants which I have agreed to accept: _____

I hereby certify *under penalty of licensure action and possible revocation of my NIW waiver* that I, the undersigned physician, personally delivered the type of healthcare services for which my NIW waiver was approved at the above address at least 40 hours per week. I further certify that my practice is using the sliding fee scale or 'no-pay' policy submitted with my waiver application for uninsured patients with household incomes at or below 200 percent of the Federal Poverty Level. All the information reported on this form is true to the best of my knowledge and belief.

 (Physician's Signature) (Date) (Telephone #) (Email Address)

PART 2 - TO BE COMPLETED BY SPONSOR/EMPLOYER:

I hereby certify *under penalty of licensure action and other liability for fraudulent claims* that the information provided on this report is true and correct to the best of my knowledge and belief. I further certify that this organization uses the sliding fee scale or 'no-pay' policy submitted with the above physician's waiver application to discount payment fees for uninsured patients with household incomes at or below 200 percent of the Federal Poverty Level.

 Organization

 Employer's Signature

 Date

 Printed/Typed Name

 Telephone Number

 Title

 E-mail Address

Please return this completed form to:

Alabama Department of Public Health
 Office of Primary Care and Rural Health
 ATTN: J-1/NIW Program Manager
 201 Monroe St., Suite 1040
 P.O. Box 303017
 Montgomery, AL 36130-3017
 Email: J-1waiverInbox@adph.state.al.us

If you have questions regarding completion of this form, call: (334) 206-5396 or Fax: (334) 206-5434 or (334) 206-0340