LOUISIANA MEDICAID MANAGED CARE REPORTING

REPORT INFORMATION

Document ID: PF170
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INFORMATION TO BE COMPLETED BY THE HEALTH PLAN

Health Plan ID: [Health Plan ID]
Health Plan Name: [Health Plan Name]
Health Plan Contact: [Contact Person's Name]
Health Plan Contact Email: [Contact Email]
Report Period Start Date: [Start Date]
Report Period End Date: [End Date]
Date Completed: [Today's Date]

Definitions and Instructions:

Please use this form as a cover sheet when submitting your information. The Disclosure of Ownership form can be found on Louisiana's Medicaid website at:

http://ldh.la.gov/assets/HealthyLa/170_Report_Disclosure_of_Ownership_03.01.2018.pdf

RFP Reference: Independent Audit