EXHIBIT 3A

LISTING OF MEDICAID ELIGIBLE DAYS FOR DSH ELIGIBLE HOSPITAL

PROVIDER NAME: _____ *CCN:* _____ *FYE:* _____ *PREPARED BY:* _____

WORKSHEET S-2, PART I, LINE (ENTER 24 OR 25 ONLY): ____ *COLUMN (ENTER 1, 2, 3, 4, 5, or 6 ONLY):* ____ *DATE PREPARED:* _____

MEDICAID PATIENT CLAIM INFORMATION							MED REC NO	ACCT OR CTRL NO	STATE ELIG CODE	MEDICAID DAYS		INSURANCE OR OTHER PAYER NAME		MEDICARE ELIGIBILITY			COM-MENT
PATIENT NAME		DOB	GEN-DER	MEDI-CAID ID NO	DATES OF SERVICE					ELIG-IBLE DAYS	LA-BOR & DEL ROOM DAYS			A/B IND	START DATE	END DATE	
LAST	FIRST				ADM	DIS						PRIM	SEC				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
TOTAL																	