PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL
DELETE RECORD FORM

Records listed below should not appear on any other form

CONTROL NUMBER	RECORD ID NUMBER	BIRTH DATE	DISCHARGE DATE	EXPLANATION

I authorize the Pennsylvania Health Care Cost Containment Council to make the above changes to my facility's data.

Date _____ PAF # _____ Quarter/Year_____Facility _____

Signature PLEASE PRINT THE FORM AND SIGN _____ Click to Print Title _____

Revised: July 2001