



Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS



Frederick P. Cerise, M.D., M.P.H.
SECRETARY

Letter of Attestation of Medical Record Destruction

All fields must be completed or claims and letter will be returned without processing.

- Due to extenuating circumstances beyond my control, I am unable to provide the requested medical documentation in support of my Medicaid claim(s).
- I attest that the medical record documentation was completely destroyed or partially destroyed and rendered unreadable and unusable on _____ by the following cause(s) (check all that apply):
Date
 flood
 fire
 Hurricane _____
 other _____ (please specify).
- The remains of partially destroyed records were disposed of by (indicate method, date, and responsible party):

- I certify that the above information is true, accurate, and complete.
- I understand that payment of this claim(s) will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.
- I certify that I am an owner or an individual legally authorized to act on behalf of the owner(s) or providers(s).

Name and Title (please print)

Relationship to Provider

Signature

Date

Provider Name

Provider Billing Number

Done and signed before the below Notary Public on _____, 2006

Notary Public

Witness

- Submitter Medicaid ID Number (if different than billing provider number): _____
- Total Number of Claims Submitted with this Letter of Attestation: _____
- Total Billed Charges of Claims Submitted with the Letter of Attestation: _____

(For internal use only) DHH approval: Yes No _____