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):
  [ ] 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: ___________

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

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