

**LOUISIANA MEDICAID PROGRAM**

**ISSUED:**

**04/01/09**

**REPLACED:**

**06/01/05**

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**CHAPTER 31: MENTAL HEALTH REHABILITATION**

**APPENDIX B: LETTER OF ATTESTATION**

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## **APPENDIX B**

## LETTER OF ATTESTATION OF MEDICAL RECORD DESTRUCTION

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

Provider Name: \_\_\_\_\_

- 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 (*check only box no. 1 or 2*):

1.  Completely destroyed; or

2.  Partially destroyed and rendered unreadable and unusable

on \_\_\_\_\_ by the following cause(s) (*check all that apply*):

Date

flood

fire

Hurricane \_\_\_\_\_

other \_\_\_\_\_ (please specify).

*If box no. 2 above is checked, I certify that I have subsequently had the medical record documentation completely destroyed by using the following method:*

\_\_\_\_\_.

- I certify that the above information is true, accurate, and complete.
- I understand that payment of this claim 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 or no**