HOSPITAL
SPECIALIZED UNIT
ATTESTATION FORM
(Louisiana Medicaid Program)

Neonatal Services

(Form is subject to change without notice)

Revised 11/20

NEONATAL SERVICES

LOUISIANA MEDICAID ATTESTATION REQUIREMENTS

Louisiana Medicaid Provider Number | | | | | | | |

National Provider Identifier (NPI) | | | | | | | | | | |

Louisiana Medicaid Provider Name: _____

Contact Name: _____

Contact Phone Number: _____

Please check the appropriate Level that you are applying for:

LEVEL II ☐ **LEVEL III** ☐ **LEVEL III REGIONAL UNIT** ☐

The above-named Facility attests its compliance with the following:

- Meets all Federal, State and local laws provided for licensing establishments of this nature, and is licensed pursuant to such law.
- Has in place the organizational and administrative structure, including neonatal services policy and procedures. A collaborative quality assessment process is active and functioning.
- Has a Medical Director and/or department chief who meets with the required professional qualifications and/or certifications and who functions within the established administrative structure.
- Has a qualified registered nurse manager available to all neonatal care units and who has specific training and experience in Neonatal services. This RN manager shall coordinate staff education with the medical director.
- Meets all external and internal physical requirements. Adequate equipment is available and maintained.
- Meets the nurse to patient ratio of Level marked.
- Meets all the requirements of Level requested and provides for the comprehensive care of high risk neonates of all categories admitted and transferred.
- Meets the requirement for the provision of obstetrics and neonatal diagnostic imaging by qualified practitioners available 24-hours a day. (If applicable to Level marked.)
- Meets the requirements for the Level marked and has the required subspecialties on staff and clinical services available to provide consultation and care in a timely manner.
- Provides for the required, qualified support personnel.

FOR LEVEL III ONLY: In addition to meeting all the requirements for a Level II NEONATAL SERVICE at a superior level.

The above-named Facility attests that it:

- Has a transfer agreement with _____, a LEVEL III Regional Unit, and will be involved in organized outreach educational programs.
- Has a neonatalogist or a licensed physician, who has successfully completed the Neonatal Resuscitation Program (NRP), or a neonatal nurse practitioner in-house at all times to meet the neonatalogist to patient ratio of 1:10.

FOR LEVEL III REGIONAL UNITS ONLY: In addition to meeting all the requirements for a Level III NEONATAL SERVICE at a superior level.

The above-named Facility attests that it:

- Has a transport team and provides for and coordinates a maternal and neonatal transport with Level I, Level II, and Level III NICU's throughout the State.
- Has reviewed all Louisiana Medicaid requirements and is in compliance with these requirements as of the date of this attestation.
- Provides evaluation of the condition of healthy neonates.
- Provides stabilization of unexpectedly small or sick neonates.
- Provides consultation and transfer agreement with Level II, Level III, or Level III Regional Unit.
- Provides resuscitation and stabilization of all inborn neonates.

NEONATAL SERVICES

ATTENTION: Read the following carefully before signing.

By this document, I hereby consent to allow State Survey Agency personnel to conduct an on-site survey to ensure that the State Medicaid requirements are met. I also agree to provide any additional information or material related to my request for Medicaid Approval that the State Survey Agency may require.

Whoever knowingly and willfully falsifies, conceals or covers up by any means, a material fact, or makes any false or fraudulent statement or misrepresentations, or makes or uses any false writing or document knowing the same to contain any false, fictitious fraudulent statement or entry, shall be fined or imprisoned or both according to State law and shall be barred from participation in Medicaid reimbursement from the date of attestation to the date of discovery.

I, therefore, attest and do sign below, in my own hand, that I an authorized agent of this Facility and all information is true, accurate, and complete.

I understand that if this Facility is found to not meet the level attested to, it may be subject to recoupment of Medicaid funds.

Print Name of the Authorized Representative	Title/Position
Signature of the Authorized Representative	Date of Signature