The reason you are being asked to sign this Signature Attestation Form is because Medicare requires legible signatures on all patient records. \*FACILITYNAME\* is assembling records in response to a Medicare audit or as part of an appeal and we must include this attestation form when signatures are not entirely legible. The patient listed below is or was your patient during the period of time noted below. We have attached the document that you signed for easy reference.

1. **Patient Information** *(completed by therapist or designee)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Full Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Medicare Number

1. **Date(s) Being Attested** *(therapist or designee check & complete the applicable**items*

[ ]  Plan of Care date (s) from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 00/00/0000 00/00/0000

[ ]  Referral date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 00/00/0000

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Attestation Statement & Signature** *(physician/NPP enter name, date & signature)*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (printed name with credentials)

attest that the signature below is my signature and that the patient noted in Box 1 was under my care during the date(s) referred to in Box 2. I attest that the information on this form is true and accurate to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil or criminal liability.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 00/00/0000 Signature with Credentials