Signature Attestation Statement

Beneficiary:

Medicare ID:

I, _____, hereby attest that the medical record entry for date(s) of service _____ accurately reflects signatures/notations that I made in my capacity as (insert provider credentials, e.g., M.D.) _____ when I treated/diagnosed the above listed Medicare beneficiary. I attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Signature: _____ Date: _____

LEGIBLY SIGN YOUR NAME (STAMPS and ELECTRONIC SIGNATURES ARE NOT ACCEPTABLE FOR THIS FORM.

Please return this completed form, if needed, with the requested documentation and the Additional Documentation Request (ADR) letter to the address listed on the ADR letter.

CID (if applicable for CERT claims): _____