Print Form

North Carolina Department of Health and Human Services
Division of Medical Assistance

Provider Attestation Form

Due to extenuating circumstances beyond my control, I am unable to provide the requested medical documentation in support of my Medicaid/SCHIP claims, as requested by

Insert Name of Company/Agency Requesting Information Here :

The medical and administrative documents were destroyed by a catastrophic event. **Attach supporting documentation (i.e., Fire report, police report, insurance claim, etc.).** Select one below.

☐ Flood	☐ Fire
☐ Hurricane	☐ Tornado
☐ Other catastrophe (explain):	

Select One:

☐ I attest that this provider's medical records and administrative documentation were completely destroyed on _____(date).

☐ I attest the medical records and administrative documentation for the date range: _____(date) to _____(date) and/or for recipient(s) _____(name) were destroyed on _____(date). However, I am providing any remaining requested medical record and/or administrative documentation. (Attach additional sheets if neccessary)

Under penalty of law, I declare, to the best of my knowledge and belief, that the information I have provided is true, correct, and complete.

_____

(Signature) (Date)

_____

(Printed Full Name) (Title)

Provider Name:	Medicaid Provider Number:
Address:	City, State, Zip:
Phone:	

Please return form to: **North Carolina Division of Medical Assistance**
Program Integrity
2501 Mail Service Center
Raleigh, North Carolina 27699-2501