MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE

ATTESTATION OF MEDICAL RECORD LOSS OR DESTRUCTION

Telephone: 573-751-3399
Toll Free: 833-818-1183
Fax: 573-526-4375

Section I: Instructions

Please complete the information in the sections below, sign and return the attestation to the address below:

Missouri Medicaid Audit and Compliance
P.O. Box 6500
Jefferson City, MO 65102

Reset Form

Section II: Provider Information

PROVIDER NAME (LEGAL BUSINESS NAME)	DOING BUSINESS AS - DBA (if applicable)		
STREET ADDRESS	CITY	STATE	ZIP CODE
COUNTY	PROVIDER TELEPHONE NO	PROVIDER FAX NO	PROVIDER E-MAIL ADDRESS
DESIGNATED CONTACT NAME	DESIGNATED CONTACT PHONE NUMBER	DESIGNATED CONTACT E-MAIL ADDRESS	
MISSOURI MEDICAID PROVIDER NUMBER	NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER		

Section III: Medical Record Loss or Destruction Information

Due to the extenuating circumstances beyond my control or unforeseen events, documentation is not available in support of my MO HealthNet claim(s). I attest that the documentation was destroyed as a result of a natural or man-made disaster or a disaster for which the Governor issued a Disaster Proclamation in the county where the records were located (Complete **1, 2 or 3** and then move on to number **4**):

☐ **1. The records were completely destroyed**	DATE DESTROYED			
LOCATION OF RECORDS AT THE TIME OF DESTRUCTION	STREET ADDRESS	CITY	STATE	ZIP CODE

OR

☐ **2. The records were partially destroyed or rendered unreadable and unusable**	DATE			
LOCATION OF RECORDS WHEN PARTIALLY DESTROYED OR RENDERED UNREADABLE AND UNUSABLE	STREET ADDRESS	CITY	STATE	ZIP CODE

OR

☐ **3. THE RECORDS WERE INVOLVED IN A CYBER-SECURITY BREACH AND/OR RANSOMWARE EVENT (EXPLAIN THE EVENT AND MITIGATION PROCEDURES**)

☐ 4. PROVIDE A SHORT DESCRIPTION OF COMPLETE OR PARTIALLY DESTROYED RECORDS

THE REMAINS OF PARTIALLY DESTROYED RECORDS WERE DISPOSED OF BY (EXPLAIN BELOW INDICATING DATE, METHOD, AND RESPONSIBLE PARTY)

Section IV: MO HealthNet Participant Information

MO HealthNet Participant Name	Departmental Client Number (DCN)
MO HealthNet Participant Name	Departmental Client Number (DCN)
MO HealthNet Participant Name	Departmental Client Number (DCN)
MO HealthNet Participant Name	Departmental Client Number (DCN)
MO HealthNet Participant Name	Departmental Client Number (DCN)

If there are more participants than those listed above, please attach a list to THIS FORM with the name(s) and corresponding DCN.

Section V: Attestation (REQUIRED)

☐ I certify that the above information is true, accurate, and complete.

☐ I certify that I am the owner or an individual legally authorized to act on behalf of the owner(s) or provider(s).

AUTHORIZED SIGNATURE	TITLE	PRINTED SIGNATURE	DATE

Section VI: Additional Information

Please complete 1 thru 5 if this form is being submitted as documentation in order to obtain payment of a Medicaid claim.

☐ 1. I understand that payment of this claim(s) 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. .	
☐ 2. Missouri Medicaid Provider Number (if different than information reported in section II above)	
☐ 3. National Provider Identifier (NPI) Number (if different than information reported in section II above)	
☐ 4. Total number of claims submitted with this letter of Attestation	
☐ 5. Total billed charges of claims submitted with this letter of Attestation	

☐ Backup of original records are not available (ELECTRONIC OR OTHERWISE)

IF THE LOSS OF RECORDS WAS DUE TO NATURAL OR MAN-MADE DISASTER, AN OFFICIAL REPORT* ATTESTING TO THE SOURCE OF THE DESTRUCTION WILL BE REQUIRED.

THIS FORM ALONG WITH ANY NECESSARY ATTACHMENTS SHOULD BE FORWARDED TO MISSOURI MEDICAID AUDIT AND COMPLIANCE (MMAC) AT THE ADDRESS LISTED IN SECTION I ABOVE **WITHIN 30 DAYS OF THE DISASTER**.

WEATHER RELATED EVENTS, SUCH AS, RAIN, FLOODS, HURRICANES, TORNADOS; ETC CAN BE CONFIRMED BY NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION (NOAA) ON A STATE AND COUNTY GEOGRAPHICAL BASIS.

* AN OFFICIAL REPORT MAY INCLUDED, SUCH AS:

- Fire which can be confirmed by local Fire Marshal;
- Explosions, such as, natural gas which can be confirmed by the local Fire Marshall or local gas company;
- Explosions, such as, chemical explosions which can be confirmed by the local Fire Marshall and the Bureau of Alcohol, Tobacco and Firearms
- Local, State, and Federal Investigative Officials can confirm explosion;
- State insurance officials which can confirm whether doctors, hospitals, and durable medical equipment (DME) suppliers applied for insurance coverage under their Insurance policies;
- Federal Emergency Management Agency (FEMA) officials which can confirm if doctors, hospitals, and DME suppliers applied for disaster recovery loans;
- Local and state investigative agencies that may be able to confirm events leading to the destruction of medical records;
- Employees or non-employees of doctors, hospitals, and DME suppliers that may have contributed to the destruction of medical records and records disclosing charges against that individual(s); and/or
- Complete details of the cyber security breach or ransomware event.

FOR OFFICAL STATE USE ONLY - DO NOT WRITE BELOW THIS LINE

DATE RECEIVED	

APPROVED ☐ DENIED ☐

AUTHORIZED STAFF SIGNATURE