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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| C:\Users\MORFCU8\Pictures\New Picture.png | MISSOURI DEPARTMENT OF SOCIAL SERVICES  MISSOURI MEDICAID AUDIT AND COMPLIANCE ATTESTATION OF MEDICAL RECORD LOSS OR DESTRUCTION | | | | | | | | | | | | | | | **Telephone: 573-751-3399**  **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 | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | 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 or 2** and then move on to number **3**): | | | | | | | | | | | | | | | | | | | | |
| 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 | |
|  | | | | | |  | | | | | | |  | | | | |  |  | |
| THE REMAINS OF PARTIALLY DESTROYED RECORDS WERE DISPOSED OF BY (EXPLAIN BELOW INDICATING DATE, METHOD, AND RESPONSIBLE PARTY) | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| 3. provide a short description of complete or partially destroyed records | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Section IV: MO HealthNet Participant Information | | | | | | | | | | | | | | | | | | | | |
| mo HealthNet participant name | | | | | | | participants state id number (dcn) | | | | | | | | | | | | | |
|  | | | | | | |  | | | | | | | | | | | | | |
| mo HealthNet participant name | | | | | | | participants state id number (dcn) | | | | | | | | | | | | | |
|  | | | | | | |  | | | | | | | | | | | | | |
| mo HealthNet participant name | | | | | | | participants state id number (dcn) | | | | | | | | | | | | | |
|  | | | | | | |  | | | | | | | | | | | | | |
| if there are more participants than those listed above, please attach a list to THIS FORM with the name(s) and corresponding dcns | | | | | | | | | | | | | | | | | | | | |
| Section V: Attestation | | | | | | | | | | | | | | | | | | | | |
| 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 the following **additional** information if this form is being submitted as documentation in order to obtain payment of a **Medicaid** claim | | | | | | | | | | | | | | | | | | | | |
| 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. . | | | | | | | | | | | | | | | | | | | | |
| Missouri Medicaid **provider** .identification number (if different than information reported in section ii above) | | | | | | | | | | | | | |  | | | | | | |
| national provider identifier **npi** number (if different than information reported in section ii above) | | | | | | | | | | | | | |  | | | | | | |
| total number of claims submitted with the letter of attestation | | | | | | | | | | | | | |  | | | | | | |
| total billed charges of claims submitted with this letter of attestation | | | | | | | | | | | | | |  | | | | | | |
| backup of original records **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 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 *noaa* on a state and county geographical basis.  \* an official report may include such things as:   * fire which can be confirmed by local fire marshal * explosions, such as, natural gas which can be confirmed by the local fire marshal or local gas company * explosions, such as, chemical explosions which can be confirmed by the local fire marshal and the bureau of alcohol, tobacco, and firearms * local, state, and federal investigative officials can confirm explosions. * State insurance officials can confirm whether doctors, hospitals, and DME suppliers applied for insurance coverage under their insurance policies. * fema can confirm if doctors, hospitals, and DME suppliers applied for disaster recovery loans. * Local and state investigative agencies may be able to confirm events leading to the destruction of medical records. * Employees or non employees of doctors, hospitals, and DME suppliers may have contributed to the destruction of medical records and there should be records disclosing charges against that individual(s). | | | | | | | | | | | | | | | | | | | | |
| FOR OFFICAL STATE USE ONLY - DO NOT WRITE BELOW THIS LINE | | | | | | | | | | | | | | | | | | | | |
| DATE RECEIVED | | | |  | | | | | | | | | | | | | | | | |
| APPROVED DENIED | | | | | | | | | | | | | | | | | | | | |
| AUTHROIZED STAFF SIGNATURE | | | |  | | | | | | | | | | | | | | | | |

MMAC (MRLOD) 2012-06