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| C:\Users\MORFCU8\Pictures\New Picture.png | MISSOURI DEPARTMENT OF SOCIAL SERVICESMISSOURI MEDICAID AUDIT AND COMPLIANCEATTESTATION 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 ComplianceP.O. Box 6500Jefferson 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