

## Medical Record Signature Attestation Statement

**NOTE:** This form provides a suggested format for a signature attestation statement. Submission of a signature attestation statement and use of this form is optional.

<b>Name of Patient:</b>	
<b>Medicare Number:</b>	

I, \_\_\_\_\_, hereby attest that the medical record entry  
*Print full name of the physician/practitioner*  
for \_\_\_\_\_ accurately reflects signatures/notations that I made in  
*Date of Service*  
my capacity as a(n) \_\_\_\_\_ when I treated/diagnosed the above  
*Insert credentials, e.g., M.D.*  
listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or, criminal liability.

\_\_\_\_\_  
Signature of Author of the Medical Record

\_\_\_\_\_  
Date

*In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and contain sufficient information to identify the beneficiary. Reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question (even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements).*

