 

Community Health Connections Health Home

**Billing Attestation Form**

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| Staff Member Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Care Management Agency: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Billing Month: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or a designee from the Care Management Agency, have reviewed all billing and HML assessments and attest that:

[ ]  All Members identified as having a billable service for the month have a service that satisfies the CHC policies and procedures regarding billable services.

[ ]  All billable services provided to Members are documented in the Member’s electronic health record.

[ ]  Documentation supporting the responses to each Member’s HML was obtained and recorded in the individual’s electronic health record.

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |