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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 |