MEDICAL MUTUAL®

Medical Record Attestation Form

Member First Name: _____ Member Last Name: _____

DOB: _____ Member ID: _____

Claim #: _____ ENTR ID: _____ Masked ID: _____

Issuer Name: _____ Issuer HIOS ID: _____

Date of Service: _____

"I, _____ [print full name of the physician/practitioner], hereby attest that the medical record entry for _____ [date of service] accurately reflects signatures/notations that I made in my capacity as _____ [insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed individual. 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."

Provider Signature: _____

Date:_____

Please fax completed form to the attention of the Risk Assessment Department at (877) 480-3106.