

Saved as a word document so providers can cut & paste onto their own letterhead of the main provider to submit the attestation **(note this is only for the 1<sup>st</sup> page of the attestation):**

**GENERAL INFORMATION**

1) Main Provider (e.g., Hospital) Information:

Name: \_\_\_\_\_

Medicare No.: \_\_\_\_\_

Exact Physical Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Provider-based Facility Information:

Name: \_\_\_\_\_

Medicare No.: \_\_\_\_\_

Exact Physical Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Attestation Contact Name and Phone Number:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

4) Main Provider's Fiscal Intermediary: \_\_\_\_\_

5) \_\_\_\_\_ Is the main provider accredited? (Y or N)

5a) If Yes to question 5), by Whom: \_\_\_\_\_

6) \_\_\_\_\_ Date the facility/organization became provider-based with the main provider

**Indicate Y or N below:**

7) \_\_\_\_\_ Is the facility/organization part of a multi-campus hospital?

8) \_\_\_\_\_ Is the facility a Federally Qualified Health Center (FQHC)?

If yes, and if the FQHC meets the criteria at Section 413.65(n), it need not attest to its provider-based status. The provider-based rules do not apply to other FQHCs that do not meet the criteria at Section 413.65(n), and an attestation should not be submitted.

9) \_\_\_\_\_ Is the facility a RHC?

If yes, Medicare will not make a provider-based determination if the main provider has 50 or more beds, or is otherwise eligible for the RHC upper payment exception.

9a) \_\_\_\_\_ If yes, does the main provider have 50 or more beds?

9b) \_\_\_\_\_ If yes, does the RHC qualify or is eligible for the RHC upper limit payment exception?

10) \_\_\_\_\_ Date the Provider began providing services **-- OR --**

\_\_\_\_\_ Date the Provider "May Begin" provider services