1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339

Provider Attestation Regarding IEP/IFSP for Outpatient Therapy Services

_____
Member Name

_____
Member ID Number

I conducted a reasonable review of the facts regarding the therapy services recommended for the above-referenced member, including a discussion with the parent (RE: other services that are currently provided), who attested the member does not have an existing Individualized Educational Plan (IEP) or Individualized Family Service Plan (IFSP).

I understand that under my provider participation agreement, [CMO Name], and applicable regulators including the Centers for Medicare and Medicaid Services, and the Georgia Department of Community Health or their representatives may inspect and evaluate my records related to members and the provision of and payment for services to audit compliance with this review requirement, and other contractual requirements and federal and state laws and regulations.

NOTE: If members do have an existing IEP or IFSP, it should be submitted along with the request for treatment.

_____
Provider Signature

_____
Provider Printed Name

_____
Title

_____
Provider Medicaid Identification Number

_____
Date

_____
Contact Phone Number

_____
Contact Fax Number