

## Signature Attestation Statement

Beneficiary \_\_\_\_\_

HICN \_\_\_\_\_

I, \_\_\_\_\_, hereby attest that the medical record entry for date(s) 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 Medicare beneficiary. I attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Signature \_\_\_\_\_

Date \_\_\_\_\_