ACO Logo

Patient Attestation: DME not Received

I _____ (patient name) attest to the best of my knowledge that I have never/did not received the following Durable Medical Equipment (DME):

DOS	CPT Code	CPT Description	Paid Amount	DME Provider

Authorization to Disclose Health Information

1. I authorize the use or disclosure of the above-named individual's health information as described below.
2. The type and amount of information to be used or disclosed is as follows:
   Attestation, Name, General Demographics and Dates of Visits to [DME company]. No additional personal information will be shared.

3. This information may be disclosed to and used by the following individuals:
   Federal and local law enforcement for the purpose of: **Medicare compliance and payment recoupment, if applicable.**

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the organization noted in the footer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.
5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for subsequent unauthorized disclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Relationship to Patient

Additionally, submitting a complaint using the link or phone number provided below may reduce your financial responsibility.

Submit a Hotline Complaint: https://oig.hhs.gov/fraud/report-fraud/
File a Complaint Online: https://tips.oig.hhs.gov/
1-800-HHS-TIPS (1-800-447-8477)
TTY: 1-800-377-4950