CareSource

Provider Attestation Regarding IEP/IFSP for Outpatient Therapy

_____
Services Member Name

_____
Member ID Number

I have conducted a reasonable review of the facts regarding the therapy services recommended for the above referenced member, including a discussion with the parent regarding other services that are currently provided. Based upon my review and attestation from the parent, 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, 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 the member does have an existing IEP or IFSP, it should be submitted along with the request for treatment. Providers must date this form as of the date of signature.

_____
Provider Signature

_____
Print Name

_____
Title

_____
Provider Medicaid Identification Number

_____
Date

_____
Contact Phone Number

_____
Contact Fax Number