**ATTESTATION FORM FOR ANCILLARY LOCATION**

**FOR HOSPITALS**

**Ancillary Locations Not Located Within the Main Building**

**(Complete one form for each additional location)**

HOSPITAL NAME:

Ancillary Location Name:

Ancillary Location Address (include city):

(**BE SPECIFIC**: Located in a specific suite(s) # within building, specific floor, etc.)

Please attach a copy of the organization chart and clearly indicate where the responsibility of this ancillary location fits into the hospital organization.

# of Highway Miles from Main Hospital:       # of Radius Miles from Main Hospital:

List all hospital services (indicate appropriate suites, if applicable) being provided at this ancillary location:

For the time employees are working at this ancillary location are their hours charged to the hospital’s cost report?

YES  NO

While working at this ancillary location are the employees under the supervision of a hospital employee?

YES  NO  If no, explain:

Are the services at this ancillary location under the supervision of the hospital’s organized medical staff?

YES  NO  If no, explain:

How are referrals made to this location?

Are the services being billed as a hospital service under the hospital’s Medicare/Medicaid agreement (hospital’s provider number)?

YES  NO

If No, explain how these services are billed (be specific)?

Name of Person Completing this form:

Title:       Date: