**ATTESTATION FORM FOR ANCILLARY LOCATION**

**FOR PROVIDER OTHER THAN A HOSPITAL**

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

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

LICENSED PROVIDER’S 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 Provider:       # of Radius Miles from Main Provider:

List all provider 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 main provider’s cost report?

YES  NO

While working at this ancillary location are the employees under the supervision of an employee of the main provider?

YES  NO  If no, explain:

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

YES  NO  If no, explain:

How are referrals made to this location?

Are the services being billed under the main provider’s Medicare/Medicaid agreement (main provider’s provider number)?

YES  NO

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

Name of Person Completing this form:

Title:       Date: