**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: