Co-Location Attestation

This attestation is to be completed by a provider that seeks to enroll a location that is co-located with another provider enrolled in the Medical Assistance Program. A separate attestation must be completed by both of the providers that are providing services at the service location.

On behalf of _____ ("Provider") which will be co-locating with _____ which is a _____, located at the following address _____,

I attest to the following:

Any agreements for the use of space or equipment or for personnel or management services by the providers must meet the requirements in 42 CFR § 1001.952(b),(c), and (d);

The provider shall comply with all other Federal and State laws and regulations prohibiting illegal kickbacks and referrals;

The space used by the providers shall be separated by walls, partitions, or other means sufficient to guarantee privacy to patients;

The provider will take whatever other measures are necessary to ensure and maintain patient confidentiality in accordance with applicable laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

The provider shall advise patients that they have freedom of choice in selecting providers and that the patients may choose any Medical Assistance enrolled provider;

The provider shall also display signage, approved by the Department of Human Services, displayed in a prominent place, such as a waiting room or at the point of check-in, stating that patients may choose any enrolled provider to provide services;

The provider will not make any direct or indirect referral arrangements between practitioners and other providers of medical services or supplies but may recommend the services of another provider or practitioner;

The provider will not make automatic referrals.

This attestation does not amend, reduce or eliminate any requirements imposed by State and Federal law and regulation relating to, or governing, the individual provider's participation in the Medical Assistance Program.

I possess all necessary powers and authority to execute this Written Attestation on behalf of the provider set forth below and in doing so bind the provider.

I understand that any false statements made therein are subject to the penalties contained in 18 Pa. C.S. § 4904, relating to any unsworn falsifications to authorities.

Printed or Typed Name: _____

Signature: _____ Date:_____

Provider Entity: _____

Provider Type: _____

NPI #: _____