



## Provider Attestation for Outpatient Therapy Services

\_\_\_\_\_  
WellCare Member Name

\_\_\_\_\_  
WellCare Member Identification Number

I conducted a reasonable review of the facts regarding the therapy services recommended for the above referenced member. Based upon my review findings and to best of my knowledge, information and belief, the member is not receiving the same type of or similar therapy services as those requested in the attached Ancillary Services Authorization Request and Plan of Care from local education agencies. In addition, in the event the above referenced member is receiving services under an IEP or IFSP at the school, and the therapist is requesting additional coverage outside of the school, the additional requested treatment is medically necessary to correct or ameliorate a health condition.

I understand that under my provider participation agreement, WellCare and applicable regulators including the Centers for Medicare & 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.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Provider Medicaid Identification Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contact Phone Number

\_\_\_\_\_  
Contact Fax Number