Uninsured Claims Program Patient Attestation for COVID-19 Testing

Date of Service: _____

Name (First, MI and Last): _____

Address: _____

Date of Birth: _____Gender: _____

Social Security Number: _____ State of Residence_____

Driver's License or State ID: _____

I confirm that I, _____am uninsured at the time of service. I do not have coverage through an individual or employer sponsored plan, a federal healthcare program, or the Federal Employees Health Benefits Program, Medicare, or Medicaid. My health coverage status is "uninsured".

I authorize the services to be billed to the Government Funded Uninsured claims program on my behalf. I understand I will not be billed for these services.

Signature: _____Date:_____

Attestation

Best efforts were made to confirm that the patient was uninsured at the time the services were provided (i.e., for claims for COVID-19 Testing and Testing-Related Items and Services and verify that the patient does not have coverage through an individual or employer-sponsored plan, a federal healthcare program, or the Federal Employees Health Benefits Program, Medicare/Medicaid.