Commercial Insurance Coverage Provider Attestation Form

(use in lieu of EOB for KY Medicaid Coordination of Benefits)

*Provider Name: _____

*Provider Medicaid ID#: _____ *Provider NPI #: _____

*Member Name: _____

*Member Medicaid ID#: _____ *Member DOB: _____

Member Address: _____

*Primary Insurance Carrier Name: _____

Primary Insurer Address: _____

*Policy #: _____

*Policy Start Date: _____ *Policy End Date: _____

*Date Primary Insurance Filed (Date required for acceptance): _____

*Date of Primary Insurer Denial: _____

If No Response From Primary Insurer After 120 Days From Submission Date, Indicate Here With "X": _____

*Provider Billing Office Contact Name: _____

*Provider Billing Office Contact #: _____

*Provider Billing Officer Signature (required to be accepted): _____

*Form Completion Date: _____

*Required data for form acceptance