Washington State Health Care Authority

Oral Health Connections Patient Attestation Form

Date	Client ID		Provider NPI Number	
First name	Middle initial	Last name		Age
Address				
City			State	ZIP code
Phone number	Email			

The client must complete and sign this form before the Health Care Authority (HCA) will pay for services.

I, _____, attest that I have a medical diagnosis and am currently under treatment for (check those that apply):

☐ Pregnancy Date of diagnosis _____	☐ Diabetes Date of diagnosis _____

I am being treated for my diabetes and/or pregnancy by:

1	Medical provider name	Medical clinic name	Clinic phone number
2	Medical provider name	Medical clinic name	Clinic phone number
3	Medical provider name	Medical clinic name	Clinic phone number
4	Medical provider name	Medical clinic name	Clinic phone number

Please use back of form for additional providers and clinics.

Client Printed Name	Client Signature	Date
Provider Printed Name	Provider Signature	Date

This form must be completed and all signatures present upon date of delivery. This will be the date the Health Care Authority (HCA) will expect to see on your billing. A copy must be kept in your client file and be provided to HCA upon request to determine that all requirements of WAC 182-535-1270 have been satisfied.