

**HOSPITAL CHARGEMASTER/OVERVIEW FORM  
ATTESTATION OF COMPLETENESS AND ACCURACY**

**FACILITY NAME:** \_\_\_\_\_

**FACILITY ID NUMBER:** **MED** \_\_\_\_\_

**REPORTING TYPE:** **(CHECK ONE)**      **EFFECTIVE DATE:** \_\_\_\_\_

**Change (indicate effective date above)**

**Annual**

**ATTESTATION BY ADMINISTRATOR OF FACILITY OR DESIGNEE (CHECK ONE)**

I attest that, to the best of my knowledge and belief, all information in this *Chargemaster and Rates and Charges Overview Form* is accurate and complete.

**OR**

I have personal knowledge that some of the information in this *Chargemaster and/or Rates and Charges Overview Form* is not accurate or not complete. I attest that, to the best of my knowledge and belief, all information in the report is accurate and complete, except the information identified in a document accompanying this form that:

- 1) Describes the inaccurate or incomplete information and the circumstances that make the information inaccurate or incomplete, and
- 2) States what actions the facility is taking to correct the inaccurate information or make the information complete.

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

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Signature (Administrator of Facility or Designee)  
(REQUIRED)**

\_\_\_\_\_  
**Date**

**SUBMIT ALL FINANCIAL REPORTING DOCUMENTS AS EMAIL ATTACHMENTS TO:**  
[costreporting@azdhs.gov](mailto:costreporting@azdhs.gov)