

# Attestation of Completeness and Accuracy Hospital Discharge Data Reporting

Facility Name: \_\_\_\_\_

**Reporting Period:** Jan - Jun discharges of Year: \_\_\_\_\_ First Half/Deadline August 15<sup>th</sup>

**OR** Jul - Dec discharges of Year: \_\_\_\_\_ Second Half/Deadline February 15<sup>th</sup>

Discharge Data File Type(s) (check all that apply):

Hospital Inpatient

Hospital Emergency Department

## ATTESTATION BY ADMINISTRATOR OF FACILITY OR DESIGNEE

I attest that, to the best of my knowledge and belief, all information in the above referenced hospital discharge data report(s) is accurate and complete.

### OR

I have personal knowledge that some of the information in the above referenced hospital discharge data report(s) is not accurate or not complete. I attest that, to the best of my knowledge and belief, all information in the report(s) 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 hospital is taking to correct the inaccurate information or make the information complete.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

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

\_\_\_\_\_  
Date

**You may Scan/Email or transfer this document via the secure server with your data submission. Name this document Facility ID\_attest\_reporting\_period.pdf e.g. MED1234\_attest\_201601.pdf**

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