HOSPITAL
SPECIALIZED UNIT
ATTESTATION FORM
(Louisiana Medicaid Program)

Transplant Unit Criteria

(Form is subject to change without notice)

TRANSPLANT UNIT CRITERIA

LOUISIANA MEDICAID ATTESTATION REQUIREMENTS

Louisiana Medicaid Provider Number	| | | | | | | | |
National Provider Identifier (NPI)	| | | | | | | | | | |
Louisiana Medicaid Provider Name:	
Contact Name:	
Contact Phone Number:	( ) -

The above-named Facility attests its compliance with the following:

- Meets all Federal, State and local laws provided for licensing establishments of this nature, and is licensed pursuant to such law.
- Has in place the organizational and administrative structure, including adequate policy and procedures, to function as a Transplant Unit. The unit is a member of the Organ Procurement Transplant Network (OPTN). A written log is maintained containing: patient loss and reason; graft loss/failure; source of graft; date of procedures.
- Has the minimum designated qualified staff: a transplant Surgeon; a transplant physician; a clinical transplant coordinator; a social worker; a dietitian; a data coordinator and a financial coordinator. The Medical Director meets the qualifications of education, training, and research involvement and functions within the established administrative structure.
- Has written patient selection criteria. The number and types of transplants and the specific organ survival rates within the past year are maintained.
- Meets all external and internal physical requirements. Adequate equipment is available and maintained.
- Has reviewed all Louisiana Medicaid requirements and is in compliance with these requirements as of the date of this attestation.

ATTENTION: Read the following carefully before signing.

By this document, I hereby consent to allow State Survey Agency personnel to conduct an on-site survey to ensure that the State Medicaid requirements are met. I also agree to provide any additional information or material related to my request for Medicaid Approval that the State Survey Agency may require.

Whoever knowingly and willfully falsifies, conceals or covers up by any means, a material fact, or makes any false or fraudulent statement or misrepresentations, or makes or uses any false writing or document knowing the same to contain any false, fictitious fraudulent statement or entry, shall be fined or imprisoned or both according to State law and shall be barred from participation in Medicaid reimbursement from the date of attestation to the date of discovery.

I, therefore, attest and do sign below, in my own hand, that I an authorized agent of this Facility and all information is true, accurate, and complete.

I understand that if this Facility is found to not meet the level attested to, it may be subject to recoupment of Medicaid funds.

Print Name of the Authorized Representative	Title/Position
Signature of the Authorized Representative	Date of Signature MM/DD/YYYY