



Doc Type 4128

Attestation Form

For the Provision of Telehealth Services by Georgia's Local Education Agencies (LEAs)

The _____, has enrolled as an originating site
(Name of LEA)

for Telehealth Services, under the Early and Periodic Screening, Diagnostic and Treatment (Health Check) Program, with the Georgia Department of Community Health (DCH) Division of Medical Assistance Plans. In order for the Local Education Agency (LEA) to be eligible to receive Medicaid reimbursement for a facility fee for telemedicine services when operating as the originating site, the LEA must comply with the current DCH Georgia Medicaid Telemedicine Handbook – Connecting Georgia.

By signing this document, the LEA's officer, authorized by the LEA to submit this form, attests that s/he has reviewed it, and affirms that the LEA will comply with the telemedicine requirements as established in the current DCH Georgia Medicaid Telemedicine Handbook – Connecting Georgia - and any future amendments.

Signature of Signer
(CEO, CFO, or Superintendent)

Title of Signer

Date

Printed/Typed Name of Signer

Address of Signer
(street or P.O. Box, city, state, 5-digit zip)

LEA provider ID number

() _____
Contact Phone Number

() _____
Fax Number

Email Address