Attestation of Completeness and Accuracy
Illinois Licensed ASTC Discharge Data Reporting

Facility Name/City: _____

Reporting Period: _____ Date: _____

Due 15 days after final quarter closing

Discharge Data File Type(s) (check all that apply; one form per service not required):

☐ Illinois Licensed ASTC Outpatient Surgery Discharge Data* ☐ Imaging Data

ATTESTATION BY ADMINISTRATOR OF FACILITY OR DESIGNEE

☐ I attest that, to the best of my knowledge and belief, all information in the above referenced data reported is accurate and complete.

OR

☐ I have personal knowledge that some of the information in the above referenced data reported is not accurate or not complete. I attest that, to the best of my knowledge and belief, all information in the reported data 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.

_____ _____

Printed Name Title

_____ _____

Signature (Administrator of Facility or Designee) Date

NOTE: this form should be printed, signed by the facility administrator or designee, and scanned to a PDF document. Alternatively, apply a digital signature. Save the Affirmation Statement as

XXfacilitynamecityYRQ.PDF, where XX=OS, IM, MU**; YRQ=Calendar year and quarter of data

Send as email attachment to this address: DPH.DischDataAffirm@Illinois.gov

The body of the submitted email message should contain one of the words Affirmation, Affirm, Attestation or Attest (case is not important). The presence of one of these words and the attachment noted above are required for acceptance. Note: only one reply per day per sending address is sent.

* Outpatient surgery performed at a free standing ASTC
** MU=Multiple data types affirmed