

Attestation of Completeness and Accuracy Illinois Hospital 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):

- Hospital Inpatient Hospital Emergency Department**
 Outpatient Surgery* Hospital Observation Care**

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 reported is accurate and complete.

OR

- I have personal knowledge that some of the information in the above referenced hospital discharge 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 hospital 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

XXhospitalnamecityYRQ.PDF, where XX=IP, OP, ED, OC, MU***, YRQ=Calendar year and quarter of data

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

* Outpatient surgery performed at hospital or hospital-owned ASTC

** Beginning with 1st quarter 2009 discharges (affirmation not required for testing quarters)

*** MU=Multiple data types affirmed