AmeriHealth Caritas Louisiana

Child Support Enforcement Wait and See Period Attestation

Patient information			
Last name:	First name:	MI:	Suffix:
Date of birth (mm/dd/yyyy):	Sex: ☐ Male ☐ Female	Medicaid ID number:	
AmeriHealth Caritas Louisiana member ID number:			

Attesting provider information			
Provider name:			
NPI:	Medicaid provider ID number:	Group number:	
Service location address:			
City:	State:	ZIP:	Phone number:

Claim information		
Date of service (from):	Date of service (to):	
Third party originally billed:		
Policy number:	Group number:	Date third party billed:
Processing remark codes:		

Attestation

I, _____, have provided a service to an AmeriHealth Caritas Louisiana member who is subject to third party liability derived from an absent parent whose obligation to pay child support is being enforced by the State Title IV-D agency. By signing this document, I attest that I have billed the member's liable third party insurer prior to billing AmeriHealth Caritas Louisiana, have not received payment, and 100 days have elapsed since the third party was billed.

Signature:	
Printed name:	Date: