**Attestation Form**

Please make copies of this page and fill out for each member as appropriate. Save a copy in the medical record.

1. Fill in all information requested below
2. Sign and date at bottom of the form. Include credentials
3. Fax the form to **833-667-1532** or send to our secure email **MIHEDIS@mhplan.com**

**Patient Name:** _____ **DOB:** _____ **ID#:** _____

| **Osteoporosis Management in Women Who Had a Fracture** |
|---|
| ☐ **BMD Completed**<br><br>Date of Service: ____/____/_____<br>Findings: _____<br>Location: _____ |

Signature:_____ Credentials: _____ Date: _____

*Meridian is proud to serve Medicaid members in the state of Michigan. The information presented here is also representative of our affiliated and newly refreshed Wellcare brand of Medicare Advantage products serving members across the country. If you have any questions, please contact Provider Relations.*