



## Overlapping Authorization Member Attestation Letter

Date: \_\_\_\_\_

I, \_\_\_\_\_ attest that I am no longer receiving care at another facility and I am only receiving services below at \_\_\_\_\_ as of \_\_\_\_\_.

**Service (Check all that apply):**

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Chiropractic Services

Patient/ Parent/ Guardian Signature: \_\_\_\_\_

Health Plan: \_\_\_\_\_

Member ID: \_\_\_\_\_

Member Date of Birth: \_\_\_\_\_