



Medicare

Signature Attestation

CMS requires that we maintain a registry of Physician signatures for signature verification. Please complete the form below and return to our office at your earliest convenience. Thank you.

Please sign your name – *stamps and electronic signatures are not acceptable for this form.*

Signature: _____ **Initials:** _____

Name: _____

Credentials: _____ **NPI #** _____

Date: _____

Please return to:

THA Group
3 West Perry St
Savannah, GA 31401
912.629.2727 tel
912.629.2729 fax
www.THAGroup.org