COUNTY OF SAN BERNARDINO
DEPARTMENT OF BEHAVIORAL HEALTH
PROVIDER ATTESTATION - 90 Day Rule

Contract Agency Name:

Reporting Unit	Client Name	Simon Client Number	Service Date	Procedure Code	OHC Claimed Date	90 Day Date
** My name affirms that the provided client service information adheres*						
to the State's Medi-cal Claiming Ninety Day Rule.						
	Name	**Title**		Date		