**COUNTY OF SAN BERNARDINO**

DEPARTMENT OF BEHAVIORAL HEALTH

PROVIDER ATTESTATION - 12 Month Rule

**Contract Agency Name:**

| Reporting Unit | Client Name | Simon Client Number | Service Date | Procedure Code | OHC Claimed Date | 12 Month Rule Date |
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| ** My name affirms that the provided client service information adheres* | | | | | | |
| *to the State's Medi-cal Claiming Twelve Month Rule.* | | | | | | |
| | Name | **Title** | | Date | | |
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