By my signature below, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Name*), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Title*), of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Network Name)* attest and certify as follows:

□ I am authorized to sign this *Attestation* on behalf of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Network Name*).

□ I have read the data call instructions, and I am familiar with the data requested by the Workers’ Compensation Research and Evaluation Group (REG).

□ Except for the data and information explained below (if any), all of the requested information described in the data call instructions has been submitted to the REG, and it is complete and accurate.

□ The information and documents described in the data call instructions are accessible to the REG under Texas Labor Code §405.004(c).

□ All data elements checked below are complete, accurate, and in the requested format.

□ A data call submission is not considered a timely submission until it is complete, accurate, and in the requested format.

□ Failure to submit data as requested may result in an enforcement referral.

Please check the following fields if they are complete, accurate, and in the requested format:

□ Name of Workers' Compensation Network

□ TDI Network Certification Number (if network is certified)

□ Network Patient Social Security Number

□ Network Patient Last Name

□ Network Patient First Name

□ Network Patient Street Address (primary)

□ Network Patient Street Address (secondary, if available)

□ Network Patient City of Residence (primary)

□ Network Patient City of Residence (secondary, if available)

□ Network Patient State of Residence (primary)

□ Network Patient ZIP Code (primary)

□ Network Patient ZIP Code (secondary, if available)

□ Network Patient Phone Number (primary)

□ Network Patient Phone Number (secondary, if available)

□ Network Patient Date of Injury

□ Date Patient was First Treated in Network

□ Insurance Carrier Federal Employer Identification Number

□ Insurance Carrier Claim Number

□ I certify that the data elements not checked above (if any) are not complete, accurate, or in the format requested for the reasons stated below:

­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Representative

­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title

­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date