

## DRUG MEDI-CAL (DMC) CLAIM SUBMISSION CERTIFICATION - COUNTY CONTRACTED PROVIDER

County Name: \_\_\_\_\_

Provider Name (Legal Entity): \_\_\_\_\_

DMC Number(s): \_\_\_\_\_

Service Facility Location NPI(s): \_\_\_\_\_

DMC Submission Identifier: \_\_\_\_\_

*FOR COUNTY USE ONLY:*

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

EDI File Name: \_\_\_\_\_

EDI File Submission Date: \_\_\_\_\_

### COUNTY CONTRACTED PROVIDER CERTIFICATION

As required by 42 CFR Part 455.18, this is to certify that the claim file information submitted by the provider in the DMC submission identified above is true, accurate and complete. I understand that payment of this claim file will be from Federal, State, and/or County Realignment funds, and that any falsification, or concealment of material facts, may be prosecuted under Federal and/or State laws.

I hereby agree to keep such records as are necessary to disclose fully the extent of the services provided to individuals under the State's Title XIX and Title XXI plan and to furnish information regarding any payments claimed for providing such services as the State Department of Health Care Services or the Department of Health and Human Services may require. I further agree to accept as payment in full the amount paid by the Medi-Cal program for those claim files submitted for payment under the program with the exception of authorized deductible, co-insurance, or similar cost sharing charge.

I certify that the services identified in the above identified DMC submission were medically indicated and necessary to the health of the patients and were personally furnished by me or an employee working for the provider.

Printed Name: AUTHORIZED SERVICE PROVIDER

Signature: AUTHORIZED SERVICE PROVIDER

Phone Number

Date Signed