STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY | DEPARTMENT OF HEALTH CARE SERVICES

DRUG MEDI-CAL (DMC) CLAIM SUBMISSION CERTIFICATION - COUNTY OPERATED PROVIDER(S)

County Name: _____

Federal Tax Identification Number: _____

EDI File Name: _____

EDI File Submission Date: _____

COUNTY OPERATED PROVIDER CERTIFICATION

As required by 42 CFR Part 455.18, this is to certify that the claim file information submitted to the State Department of Health Care Services for providers operated by the above-name county in the file specified 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 claims 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 Electronic Data Interchange (EDI) file were medically indicated and necessary to the health of the patients and were personally furnished by me or an employee working for the county.

Printed Name: AUTHORIZED CLAIM SUBMITTER		
Signature: AUTHORIZED CLAIM SUBMITTER	Phone Number	Date