STATE OF CALIFORNIA – Health and Human Services Agency Department of Health Care Services

DRUG MEDI-CAL CERTIFICATION FOR FEDERAL REIMBURSEMENT

Date (mm/dd/yyyy)	County Code	County
	Claim Electronic Data Interchange (EDI) Filename	

	Total Dollar Amount
Total Actual Expenditures	

CERTIFICATION FOR SERVICES RENDERED:

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Drug Medi-Cal (DMC) Services in and for said claimant; that I am authorized to sign this certification on behalf of the County; that I have not violated any of the provisions of Section 1090 et. seq. of the Government Code; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with law. The County certifies under penalty of perjury that all claims for services provided to County-substance use disorder clients have been provided to the clients by the County; that the services were, to the best of the County's knowledge, provided in accordance with the client's written treatment plan; and that all information submitted to the Department is accurate and complete. The County understands that payment of these claims will be from federal and/or state funds, and any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The County agrees, pursuant to Section 433.32 of Title 42, Code of Federal Regulations (CFR), to keep for a minimum of three years and retained beyond the three-year period if audit findings have not been resolved, a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The County agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Care Services (DHCS); California Department of Justice, including its Division of Medi-Cal Fraud and Elder Abuse; Office of the State Controller; U.S. Department of Health and Human Services; or their duly authorized representatives. Services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

I FURTHER CERTIFY under penalty of perjury to the following: An assessment of the beneficiary was conducted in compliance with the requirements established in the DMC contract with DHCS; the beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the beneficiary; the services included in the claim were actually provided to the beneficiary; medical necessity was established for the beneficiary as defined under Title 22, California Code of Regulations, § 51341.1, for the service or services provided, for the timeframe in which the services were provided; a client plan was developed and maintained for the beneficiary that met all client plan requirements established in the DMC contract with DHCS.

Date:_____ Signature:_____

County Representative

Executed at:_____, California.

The signed original of this form must be retained by the county and presented upon request. If you have any questions, please contact the DHCS Medi-Cal Claims Customer Service Office at MedCCC@DHCS.ca.gov.