North Carolina Department of Health and Human Services

Division of Medical Assistance

PROVIDER CERTIFICATION FOR SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

A separate certification is required for each individual in the group in addition to the group certification.

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

_____

*Medicaid Provider Name (must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

_____

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

_____

Street Address Line 2

_____

*City *State *Zip Code + Four (Last 4 digits required)

_____

*Signature of Applicant or Authorized Individual *Date

_____

*Printed Name and Title

DMA/FISCAL AGENT APPROVAL

Acceptance Date: _____ by _____