CERTIFICATION OF ANY INFORMATION REQUIRED BY THE STATE AND CONTAINED IN CONTRACTS, PROPOSALS, AND RELATED DOCUMENTS RELATING TO PAYMENT UNDER THE MEDICAID PROGRAM

CERTIFICATION

Pursuant to the contract(s) between Virginia and the _____ managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO Plan ,_____. The _____ MCO acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on any information required by the State and contained in contracts, proposals, and related documents submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et.al.).

The _____ MCO has reported to Virginia for the period of Health Insurer Fee Year ____ all information required by the State and contained in contracts, proposals, and related documents submitted (see Attachment 1). The _____ MCO has reviewed the information submitted for the period of _____ through _____ and I, _____, attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia is accurate, complete, and truthful.

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, _____, ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE _____ MCO. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

_____
Name
on behalf of _____

_____
Date

Attachment 1
List of Files Submitted by:

_____

File Names

UB and 1500 Claim Data
Pharmacy Data
Subcontractor Data
Provider Crosswalk
Newborn Crosswalk
Board Cert Crosswalk
Pharmacy TPL Crosswalk
Reconciliation of Financial Statements to Submitted Paid Claims Data
Control Totals
Other Information Data

File Type:

Mode of Transmission:

Date Range of Data in Files: Through