Provider Attestation – Temporary State Funding for Certain Noncitizens

This attestation confirms that the provider understands the requirements of the limited state funding available for care provided to certain noncitizens and agrees to comply with the service, coverage, billing, and documentation expectations as outlined in the provider bulletin issued on October 21, 2026. Providers acknowledge their role in ensuring continuity of care and adhering to all program rules.

Effective October 1, 2026, certain noncitizens are no longer eligible for full-benefit Medicaid coverage, pursuant to H.R. 1. Approximately 270 of these individuals who meet specific functional criteria for long-term services and supports (LTSS) have been identified as eligible for temporary payment of certain services through limited state funds. This funding will be available through June 30, 2027, or until the funds are exhausted, whichever occurs first.

Coverage Period

□ I acknowledge that this limited, temporary state funding for certain noncitizens is effective from October 1, 2026, through June 30, 2027, or until funds are exhausted, whichever occurs first.

Continuity of Care

□ I agree to continue providing authorized LTSS and related services as reflected in each member's service plan as of September 30, 2026 (when the individual was previously enrolled in full-benefit Medicaid).

Covered Services

□ I understand that this temporary state funding may cover LTSS, physician and practitioner services, hospital services, and other medically necessary services within approved arrangements.

Excluded Services

□ I acknowledge that the following services are excluded and may not be billed under this state funding:

- Pharmacy services
- Dental services
- Transportation services, including NEMT

Claims Submission

□ I agree to submit claims using existing processes for Medicaid claims, acknowledge manual review, and understand claims must be submitted within **30 days** of the date of service.

Provider Responsibilities

□ I agree to verify eligibility, maintain accurate documentation, follow DMAS guidance, and collaborate with DMAS throughout the program period.

Certification

□ By signing below, the provider or authorized representative certifies the following:

- The information provided is accurate and understands that noncompliance may result in recoupment, denial of payment, or removal from participation.
- The services furnished are medically necessary, accurate, and compliant with the requirements of these limited state funds.
- All claims submitted reflect true and correct information consistent with the services delivered.
- The provider will comply with all applicable federal and state requirements, DMAS policies and guidance.
- The provider acknowledges responsibility for maintaining documentation to support all billed services.
- The provider agrees to cooperate with DMAS regarding any audit, review, or verification of services rendered under this program.
- The provider acknowledges that DMAS will notify providers in the event funds are running out prior to the end of the eligibility period and that DMAS is not responsible for reimbursing claims after this occurs.

Provider Questions / Contact Information

Providers with questions may contact the DMAS Provider Helpline at 1-804-786-6273 or 1-800-552-8627 (Monday–Friday, 8am–5pm).

Please complete the below section and submit the signed copy to Virginia_ccp@dmas.virginia.gov

Provider Name: _____

NPI / Medicaid ID: _____

Authorized Representative Name: _____

Title: _____

Signature: _____

Date: _____

Contact Email: _____

Contact Phone: _____