EDI ANNUAL CERTIFICATION OF
ELECTRONICALLY-SUBMITTED MEDICAID CLAIMS

Certification Period runs from January 1 to December 31
Enter the year of certification in the box to the right (for instance, 2007)

4	**5**	**0**	2	9	7	5

Provider Number (7 digits) - If submission contains files for more than 1 provider, list ALL provider numbers and attach to this Certification.

National Provider Identifier (10 digits)

Submitter Name: Claims Processing Service

☑ **Submissions by Provider Rendering Services Using their own Submitter ID:**

I certify that all services rendered during the above identified Certification Period were necessary, medically indicated and were rendered by me or under my personal supervision. I have reviewed the claims information submitted and certify that it is true, accurate and complete. I agree to keep such records which will disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency, Medicaid Fraud Control Unit or the Secretary of the United States Department of Health and Human Services (DHHS) may request for five years from date of service or otherwise required by law or regulation. I agree to accept payment from the Bureau of Health Services Financing as payment in full for services and not seek additional payment from the recipient for any unpaid portion of a bill except to Spend-down Medically Needy recipients as indicated on Form 110-MNP. I agree to adhere to the published regulations of the Secretary of DHHS and the regulations, policies, criteria and procedures of BHSF Medical Assistance Program including those rules regarding recoupment.

I understand that payment and satisfaction of these claims will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable federal and state laws.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

o **Submissions by Third Party Biller (Billing Agents/Clearinghouses) Using their Submitter ID:**

I certify that the claim information submitted to Louisiana Medicaid is an exact duplicate of detailed claim line information received from the provider and has not been altered or revised except for translation to the current 837 transaction format. I certify that the information submitted in electronic format is true, accurate and complete and not materially changed by me. Additionally, I understand that payment of these claims will be from Federal and State funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

I also certify the identified provider(s) have furnished me with an EDI Annual Certification of Medicaid Claims Submitted Electronically Form on which the provider has attested to the truth, accuracy and completeness of the claim information. If I do not have a direct relationship with submitting providers, I agree to obtain an EDI Annual Certification Form from the individual(s) or entity(ies) with whom I maintain a contractual relationship. I agree to maintain these forms for a period of five (5) years.

Attach a list of provider(s) name(s) and identification numbers.

Identify all claim types that will be submitted during this Certification Period:

CLAIM TYPE ☐ 837P ☐ 837 I ☑ 837 D ☐ Non-Ambulatory Transportation ☐ Case Management ☐ Other:

SIGN HERE

DATE SUBMITTER SIGNATURE (ORIGINAL)

NOTE: Updated certification forms MUST be submitted annually. Failure to maintain a completed Certification Form on file will result in the closure of the submitter number without notice to submitter. All files submitted with closed submitter numbers will be dropped from the system without being processed.

Submit to: Unisys – EDI Department, PO Box 91025, Baton Rouge, LA 70821-9025

Revised 12/06