STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES

DRUG MEDI-CAL (DMC) CLAIM SUBMISSION CERTIFICATION - DIRECT CONTRACT PROVIDER

County:_____

Provider Name (Legal Entity):_____

Federal Tax Identification Number:_____

EDI File Name:_____

FOR STATE USE ONLY:

Analyst Name:_____

Verification Date:_____

Date to Accounting:_____

DIRECT CONTRACT PROVIDER CERTIFICATION

As required by 42 CFR Part 455.18, this is to certify that the claim file information submitted to DHCS in the above-named Electronic Data Interchange (EDI) file is true, accurate and complete. I understand that payment of this claim file will be from Federal, State and/or county realignment funds, and that any falsification, or concealment of material facts, may be prosecuted under Federal and/or State laws.

I hereby agree to keep such records as are necessary to disclose fully the extent of the services provided to individuals under the State's Title XIX and Title XXI plan and to furnish information regarding any payments claimed for providing such services as the State Department of Health Care Services or the Department of Health and Human Services may require. I further agree to accept as payment in full the amount paid by the Medi-Cal program for those claims submitted for payment under the program with the exception of authorized deductible, co-insurance, or similar cost sharing charge.

I certify that the services identified in the above identified EDI file were medically indicated and necessary to the health of the patients and were personally furnished by me or an employee working for the provider.

Printed Name: AUTHORIZED CLAIM SUBMITTER

Signature: AUTHORIZED CLAIM SUBMITTER	Phone Number	Date Signed