(1) ETIN _____ **(2)** BILLING SERVICE NAME (IF APPLICABLE) _____

eMedNY/MEDICAID MANAGEMENT INFORMATION SYSTEM

CERTIFICATION STATEMENT FOR PROVIDER BILLING MEDICAID

(3) As of (date) _____, all claims submitted electronically or on paper to the State's Medicaid fiscal agent, for services or supplies furnished

(4) by (provider name) _____

(5) (10-digit National Provider ID (NPI) -- REQUIRED unless exempted from NPI)

(6) (8-digit Medicaid Provider Number -- If NPI exempt)

will be subject to the following certification.

I am (or the business entity named in this form of which I am a partner, officer, or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim; the persons providing services, care and supplies have the necessary licensing, certification, training and experience to perform the claimed services; I have reviewed these claims; I (or the entity) have furnished or caused to be furnished the care, services, and supplies itemized and done so in accordance with applicable federal and state laws and regulations; I have read the eMedNY Provider Manual and all revisions thereto; all claims are made in full compliance with the pertinent provisions of the Manual and revisions; all claims for care, services and supplies provided at the order of another professional have to the best of my knowledge been ordered by that professional in bona fide compliance with the procedures set forth in the manual and revisions. All care, services and supplies for which claim is made are medically necessary for the treatment of the named recipient, the amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any other source other than the Medical Assistance Program; payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid; ALL STATEMENTS, DATA AND INFORMATION TRANSMITTED ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED; I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE FINED AND/OR PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY VIOLATION OF THE TERMS OF THIS CERTIFICATION, INCLUDING BUT NOT LIMITED TO FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT; taxes from which the State is exempt are excluded; all records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding these claims and payment therefor shall be promptly furnished upon request to the local Department of Social Services, the State Department of Health, the Office of the Medicaid Inspector General, the State Medicaid Fraud Control Unit or the Secretary of the Department of Health and Human Services; there has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion; I agree (or the entity agrees) to comply with the requirement of 42 CFR Part 455 relating to disclosures by providers; I (or the entity) have adopted and implemented, where applicable, an effective compliance program pursuant to New York State Social Services Law section 363-d, and have satisfied the requirements of Title 18 of the New York Codes, Rules and Regulations Part 521; the State of New York through its fiscal agent or otherwise is hereby authorized to (1) make administrative corrections to claims submitted under this agreement to enable its automated processing, subject to reversal by the provider, and (2) accept the claim under this agreement as original evidence of care, services and supplies furnished.

In submitting claims under this agreement I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the New York State Department of Health and the Office of the Medicaid Inspector General as set forth in statute or title 18 of the Official Compilation of Codes, Rules and Regulation of New York State and other publications of the Department, including eMedNY Provider Manuals and other official bulletins of the Department. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of the law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or my entity's) past, present or future status in the Medicaid program and/or imposing any duly considered sanction or penalty.

I UNDERSTAND THAT MY SIGNATURE HEREON THE ABOVE CERTIFICATION WILL APPLY TO ALL CLAIMS SUBMITTED ELECTRONICALLY OR ON PAPER, USING MY (OR THE ENTITY'S) NPI OR MEDICAID PROVIDER IDENTIFICATION NUMBER. THIS CERTIFICATION REMAINS IN EFFECT AND APPLIES TO ALL CLAIMS UNTIL SUPERSEDED BY ANOTHER PROPERLY EXECUTED CERTIFICATION STATEMENT.

PLEASE DO NOT STAPLE OR WRITE IN BAR CODE AREA

(7) (Signature) _____ **(8)** (Date) _____

(9) (Print Name and Title) _____

(10) (Telephone #) _____ **(11)** (eMail, if available) _____

STATE OF _____
COUNTY OF _____ **(12)**

On this _____ day of _____, 20____, before me personally came

_____, to me know and known to me to the individual described in and who executed the foregoing instrument, and (s)he acknowledge to me that (s)he executed the same.

(SEAL)

_____
NOTARY PUBLIC

CERTIFICATION STATEMENT INSTRUCTIONS

A Certification Statement must be completed:

1. When you are applying for an Electronic/Paper Transmitter Identification Number (ETIN) for the electronic or paper submission of New York Medicaid data. At least one Certification Statement must accompany the ETIN Application Form. If you have multiple providers that you want linked to the new ETIN, you must complete and notarize a Certification Statement for each provider that is to be linked to the new ETIN, and send the Certification Statement(s) along with the ETIN Application Form.

2. When you are adding a provider ID number to an existing ETIN, you must complete and notarize a Certification Statement for the provider ID to be added, and indicate the ETIN in the top left corner of the form.

In both instances above, if you want the provider/ETIN combination to receive remittances electronically, you must also complete an Electronic Remittance Request form for the provider(s) and ETIN you are certifying. You must do this each time you link a new provider to your ETIN. Failure to do so will result in a paper, rather than electronic, remittance for that provider/ETIN combination.

NOTE: YOU MUST BE ENROLLED IN EITHER EMEDNY EXCHANGE OR FTP PRIOR TO REQUESTING ELECTRONIC REMITTANCE. ALL DOCUMENTS PERTAINING TO ELECTRONIC REMITTANCE CAN BE FOUND AT WWW.EMEDNY.ORG OR BY CALLING THE EMEDNY CALL CENTER AT: 1-800-343-9000.

Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement. You will be asked to update your Certification Statement on an annual basis.

Please DO NOT use white-out or red ink on these forms, as they are imaged.

The numbered fields on the Certification Statement correspond with the explanations given below. Any changes to fields 1-12 must be initialed by the provider.

Field 1: **ETIN (Electronic/Paper Transmitter Identification Number)** If you are using this form to obtain an ETIN, leave this field blank. If you wish to add a provider ID number to an existing ETIN, please indicate the ETIN in the top left corner of the form.

Field 2: **BILLING SERVICE NAME** If applicable, enter the name of the billing service that the provider is enrolled with. If you are not using a billing service, leave this field blank.

Field 3: **DATE** Enter the date the Certification Statement is submitted to the fiscal agent.

Field 4: **PROVIDER NAME** Enter the name of the provider whose signature is being notarized, or name of organization.

Field 5: **10-Digit National Provider Identifier (NPI)** Enter the NPI, unless exempted from NPI.

Field 6: **8-Digit Medicaid Provider ID Number** Enter the Medicaid Provider ID number if NPI exempt.

Field 7: **SIGNATURE** Enter the signature of the individual indicated in Field 4. This must be an original signature.

Field 8: **DATE** Enter the date the Certification Statement was signed and notarized.

Field 9: **NAME AND TITLE** Print the name and the title of the person whose signature appears in Field 7.

Field 10: **TELEPHONE #** Enter the telephone number of the person whose signature appears in Field 7.

Field 11: **EMAIL ADDRESS (If Available)** If available, enter the email address of the person whose signature appears in Field 7.

Field 12: **NOTARY PUBLIC** To be completed and signed by the Notary Public. The fiscal agent cannot accept Certification Statements that are not notarized. In addition to the notary signature, NYSDOH requires a notary seal or stamp on this document. The notary's commission expiration date/year must be entered and legible. This information may be hand-written if it does not appear on the stamp/seal. The provider's name must be entered as the person who personally came before the notary.

Please mail original (FAX copies are not acceptable) completed Certification Statements to:

eMedNY
ATTN: Enrollment Support
PO Box 4614
Rensselaer, NY 12144-8614