STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES

DRUG MEDI-CAL (DMC) CLAIM SUBMISSION CERTIFICATION - COUNTY CONTRACTED PROVIDER

PROVIDER NAME, DMC NUMBER, and NPI number are all in the heading of the DMC certification letter or on your residential license.

County Name: San Mateo County

Provider Name (Legal Entity): A fictional entity - Please use the legal name as indicated in your DMC notification letter

DMC Number(s): 4196 (this is a fictional DMC number)

Service Facility Location NPI(s): 1234567890 (this is a fictional number)

DMC Submission Identifier: 4196-07-2017 (this is for June, 2017)

FOR COUNTY USE ONLY:

Receipt Date: ____________________

EDI File Name: ____________________

EDI File Submission Date: ____________________

SAMPLE

COUNTY CONTRACTED PROVIDER CERTIFICATION

As required by 42 CFR Part 455.18, this is to certify that the claim file information submitted by the provider in the DMC submission identified above 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 claim files 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 DMC submission 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 SERVICE PROVIDER
Fictional Executive Director **(this does not have to be the ED, it could be a financial manager)**

Signature: AUTHORIZED SERVICE PROVIDER	Phone Number (555) 555-5555	Date Signed August 10, 2017 **(be sure to sign after the end of the month for which your are invoicing)**

DHCS 100186 (Revised 6/2014) THIS **FICTIOUS PROVIDER WILL HAVE 3 - 100186 FORMS: 1 FOR EACH OF THEIR SEAPARATLY DMC CERTIFIED FACILITIES**.

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DEPARTMENT OF HEALTH CARE SERVICES

DRUG MEDI-CAL (DMC) CLAIM SUBMISSION CERTIFICATION - COUNTY CONTRACTED PROVIDER

PROVIDER NAME, DMC NUMBER, and NPI number are all in the heading of the DMC certification letter or on your residential license.

County Name: San Mateo County

Provider Name (Legal Entity): Sitike, Inc.

DMC Number(s): 41AA **(this covers both IOP and OP programs at 306 Spruce - it is location specific)**

Service Facility Location NPI(s): 1457646960

DMC Submission Identifier: 41AA-07-2017-retro **(this would be a late bill for Sitike)**

FOR COUNTY USE ONLY:

Receipt Date: __________

EDI File Name: __________

EDI File Submission Date: __________

COUNTY CONTRACTED PROVIDER CERTIFICATION

As required by 42 CFR Part 455.18, this is to certify that the claim file information submitted by the provider in the DMC submission identified above 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 claim files 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 DMC submission 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 SERVICE PROVIDER
Joseph Wagenhofer **(this does not have to be the ED, it could be a financial manager)**

Signature: AUTHORIZED SERVICE PROVIDER	Phone Number (555) 555-5555	Date Signed August 10, 2017 2017 **(be sure to sign after the end of the month for which your are invoicing)**

DHCS 100186 (Revised 6/2014) **SITIKE WILL SUBMIT 1 - 100186 FORM FOR THEIR TWO PROGRAMS because the form covers all treatment at that specific site**

SAMPLE