2022

EDI ANNUAL CERTIFICATION OF ELECTRONIC FILES
Certification Period: January 1 to December 31, 2022

Provider Number (7-Digits)

4	5	0				

Submitter Number

National Provider Identifier (10 Digits)

Submitter Name: _____

Primary Contact Name: _____ Email Address: _____

Secondary Contact Name: _____ Email Address: _____

o **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.

Attach a list of all Providers Names, Medicaid ID#s and NPI Numbers associated with this Submitter Number

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 materially altered or revised except for translation to the current 837 transaction format or insertion of minor data. I certify that the information submitted in electronic format is true, accurate and complete as received from the provider. Additionally, I understand that payment of these claims will be 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 that provider(s) with whom I have a direct relationship 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 (for instance, if the relationship is with a vendor), Louisiana Medicaid understands that I will not have an EDI Annual Certification Form from the individual(s) or entity(ies) with whom I do not maintain a contractual relationship. I agree to maintain all forms I am required to collect for a period of five (5) years.

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

CLAIM TYPE

☐ 837P 1500 Claim Form ☐ 837I UB4 Claim Form

☐ 837D Dental Claim Form ☐ Other

_____ _____

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.

This Certification Form can only be mailed to either address located below. The form can't be faxed or scanned and emailed.

Submit to: Gainwell – EDI Department, PO Box 91025, Baton Rouge, LA 70821-9025 Phone #: 225/216-6303 Or: 8591 United Plaza Blvd., Bldg. V, Suite 270, Baton Rouge, LA 70809