Please Type or Print Clearly	
MEDICAID PIHP Name:	**Name of Preparer/Title:**
For The Period Ending **_____, 20____** **(Month & Date) (Yr)**	**Contact Phone Number/Email Address**

Medicaid DATA Certification Statement

On behalf of the above-named Medicaid Prepaid Inpatient Health Plan (PIHP), I attest, based on best knowledge, information and belief, that all data submitted to the North Carolina Division of Medical Assistance (DMA) is accurate, complete, and true. This statement applies to all documents and data submitted by the PIHP to DMA, including, but not limited to, the following information: encounter data, other workbook or claims information, and financial information. I further attest that no material fact has been omitted from the data form and acknowledge that the information described below may directly affect the payments made to the PIHP that I represent. I understand that I may be prosecuted under applicable federal and State laws for any false claims, statements, documents, or concealment of a material fact. Additionally, I attest in accordance with 42 CFR §438.606 that the reports have been reviewed and found to be complete, accurate, and true to the best of my knowledge, information and belief and have been submitted in accordance with the PIHP contract with DMA.

I understand that any knowing and willful false statement or representation on this data submission form or attachment(s) may be subject to prosecution under applicable federal and State laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the PIHP contract.

Month of Submission: _____

*Week of submission (Please check one): Week 1___ Week 2 ____ Week 3 ____ Week 4 ____ Week 5 ____ (If necessary).

*A completed excel workbook must accompany the signed form. The files that were sent during the week identified above must be included in the excel workbook.

Signatures

This certification must be signed by the Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to the Chief Executive Officer or Chief Financial Officer.

Please check here if a delegated authority is certifying this submission. ☐

Date	Chief Executive Officer, Chief Financial Officer or Delegated Authority (Print Name and Title)	Signature