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**

DHB Encounter 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 Health Benefits (DHB) is accurate, complete, and true. This statement applies to all documents and data submitted by the PIHP to DHB, 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 DHB.

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: Week 1 ____ Week 2 ____ Week 3 ____ Week 4 ____ Week 5 ____

*A completed MS Excel workbook must accompany the signed form. The files that were sent for the weeks identified above must align with data that is included in the MS Excel document.

Signatures

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

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

_____	_____	_____
Date	PIHP Chief Executive Officer/ Chief Financial Officer or Delegated Authority - Name & Title	Signature

Please send the completed forms to:

Sonya.Harris@dhhs.nc.gov
Adolph.Simmons@dhhs.nc.gov
Deb.Goda@dhhs.nc.gov

Your contract manager:

Howard.Anthony@dhhs.nc.gov
Greg.Daniels@dhhs.nc.gov
tasha.griffin@dhhs.nc.gov