Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals

Bureau of Health Services Financing

November 6, 2009

Dear Submitter:

All submitters must have a 2010 Annual Certification Form on file with Louisiana Medicaid. This form must be on file to allow ongoing submission of electronic claims. **The deadline for the completed Annual Certification form is December 31, 2009.**
Enclosed is the following form:

- Annual Certification Form for calendar year 2010

ACTION NEEDED:
The enclosed form MUST be completed and returned to the address below on or before December 31, 2009. Failure to submit a completed Certification form will result in closure of the submitter number and all electronic files will be dropped from the system **without being processed.**

Please return to this address
Molina – EDI Department
P O Box 91025
Baton Rouge, LA 70821-9025

PROVIDER RESPONSIBILITY: If the provider is submitting directly to Medicaid with their own submitter ID the provider must ensure that all rules and regulations are followed. If the provider is using a billing agent/clearinghouse for claims submission they must ensure a similar certification form is sent to their submitter for their records. The provider should also ensure that all claims are true, accurate and complete.

THIRD PARTY BILLERS:
It is the responsibility of each third-party biller to ensure that similar certification forms are received from each provider for whom they submit electronic claims to Louisiana Medicaid. These forms must include language where the provider attests to the truth, accuracy and completeness of all claim information and that the provider understands that all claims are paid using Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. These provider Certification forms must be kept on file for a minimum of five (5) years.

FUTURE CERTIFICATION FORMS:
During the 4th Quarter of each year, correspondence will be mailed to all open submitters requesting an updated Annual Certification Form. This form must be submitted by December 31 of each year. Failure to submit the updated Certification Form timely will result in termination of the submitter number thus preventing the ability to transmit electronic claims to Louisiana Medicaid.

Please contact the EDI Department at 225/216-6303 regarding all questions.

Sincerely,

Jerry Phillips
Medicaid Director

EDI ANNUAL CERTIFICATION OF ELECTRONICALLY-SUBMITTED MEDICAID CLAIMS

2010

Certification Period: January 1, to December 31, 2010

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Provider Number (7 digits) – If submission contains files for more than 1 provider, list ALL provider numbers and attach to this Certification.

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.

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 such as provider number or recipient number. 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 from 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.

Attach a list of provider(s) name(s) and identification numbers.

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

CLAIM TYPE ☐ 837P ☐ 837 I ☐ 837 D ☐ Non-Ambulatory Transportation ☐ Case Management ☐ 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.

Submit to: Molina – EDI Department, PO Box 91025, Baton Rouge, LA 70821-9025 Phone #: 225/216-6303
Or: 8591 United Plaza Blvd., Bldg. V, Suite 300, Baton Rouge, LA 70809