Provider Certification

Vendor Billing Claim Certification

Provider Name: _____

Provider NPI or Tax ID Number: _____

By signing this statement, I, the provider representative, certify that I am responsible for the accuracy and completeness of all claims transmitted to MDCH by ***The Senior Alliance*** and their billing agent.

I acknowledge that my signature on this document to support submission of claims will indicate my organization's agreement to abide by the rules and regulations for all purposes related to Title XIX (Medicaid) reimbursement by the MDCH, including any administrative, civil and/or criminal action(s) relating to my participation in the Medicaid program. A lack of my Waiver Agent's or billing agent representative's signature on claims made on my behalf shall not be used to avoid criminal and/or civil responsibility.

This document will be kept on file to certify expenditures submitted to ***The Senior Alliance*** for reimbursement, and for reference when bills are submitted.

Name (please print): _____ Title: _____

Signature: _____ Date of Signature: _____