FORM GNOCHC-5
CERTIFICATION OF ELECTRONICALLY-SUBMITTED GNOCHC CLAIMS
Certification Period: October 1, 2010 to September 30, 2011

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

National Provider Identifier (10 digits) – If submission contains files for more than 1 GNOCHC provider, list ALL GNOCHC national provider identification numbers and attach to this Certification.

Provider Name:	
Primary Contact Name:	Email:
Secondary Contact Name:	Email:

I certify that all services rendered during the above identified Certification Period and reported electronically on Form GNOCHC-1 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 GNOCHC demonstration 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 as permitted in the GNOCHC Provider Manual. 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.

DATE

SUBMITTER SIGNATURE (ORIGINAL)

Submit to: DHH/BHSF, Waiver Assistance and Compliance, P.O. Box 91030, Bin #24, Baton Rouge, LA 70821-9030