ATTESTATION STATEMENT FOR HOSPITAL SUBMISSION OF MEDICARE ADVANTAGE CLAIMS

I hereby certify that I am familiar with the requirements of Medicare Change Request (CR) 5647 issued in July 2007 and CR 6821 issued in May 2010. _____(insert hospital name and Medicare provider numbers) has fully complied with the requirements of these CRs for the federal fiscal year (FFY) ending September 30, _____ (please identify if this certification statement is for FFY 2007 or 2008). The hospital identified above (please check one of the following):

____submitted claims for all the Medicare Advantage (MA) patients served on an inpatient basis during the FFY indicated above to its Medicare contractor as required by CRs 5647 and 6821 by August 31, 2010.

____did not serve any Medicare Advantage (MA) inpatients during the FFY indicated above and therefore has no claims to submit to its Medicare contractor as required by Medicare CRs 5647 and 6821.

____ prior to the release of this CR 6821, submitted all claims for Medicare Advantage (MA) patients served on an inpatient basis during the FFY indicated above to its Medicare contractor as required by CR 5647.

Attention: Read the following provisions of Federal law carefully before signing:

Intentional misrepresentation or falsification of any information contained herein may be punishable by fine and/or imprisonment under Federal law. Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be subject to fines and/or imprisonment. (18 U.S.C. §1001).

To the best of my knowledge, all information provided herein is true, correct and complete.

Signed: _____

(Signature of Senior Officer or Administrator of Provider)

Printed Name: _____

Title: _____

Phone Number: _____

Date: _____

Note: Original ink signature shall be received by the Audit and Reimbursement Department of your Medicare contractor no later than September 15, 2010.