STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES FINANCING

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CERTIFICATION – FEE FOR SERVICE (FFS)

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STATE OF LOUISIANA
PARISH OF _____

State Plan Qualifying Criteria:

I hereby certify that I am the _____ [title] and an authorized agent of _____ [Governmental Facility].

I further certify that

(1) as a condition of employment or contractual arrangement, the physician, physician assistant, certified registered nurse anesthetist or certified registered nurse practitioner is required to turn over his fees and his Medicaid supplemental payments to _____ [Governmental Facility] which submits claims (Non-State Owned Type A or B, State-Owned Type E); or

(2) the physician, physician assistant, certified registered nurse anesthetist or certified registered nurse practitioner has a contract with _____ [Governmental Facility] which constitutes an employer/employee type relationship and the physician, physician assistant, certified registered nurse anesthetist or certified registered nurse practitioner assigns any Medicaid supplemental payments to _____ [Governmental Facility] (Type C); or

(3) the physician, physician assistant, certified registered nurse anesthetist or certified registered nurse practitioner is party to a contract with _____ [Governmental Facility] to provide services at or in affiliation with _____ [Governmental Facility]. Governmental Facility identifies practitioner as eligible to receive the Medicaid Supplemental payment. (Non-State Owned Type D or G, State-Owned Type F);

A listing of applicable Medicaid Provider Billing IDs is attached.

Intergovernmental Transfer Agreement: (complete applicable section I. or II.)

I. Governmental to IGT same as Qualifying Governmental

I further certify that _____ [Governmental Facility] will enter into an Intergovernmental Transfer Agreement with the Louisiana Department of Health in order to fund supplemental payments for services provided by physicians, physician assistants, certified registered nurse anesthetists and certified registered nurse practitioners pursuant to the approved state plan amendment TN #17-0011.

II. Governmental to IGT is not the same as Qualifying Governmental

I hereby certify that I am the _____[title] and an authorized agent of _____[Governmental Facility to IGT].

I further certify that _____ [Governmental Facility to IGT] will enter into an Intergovernmental Transfer Agreement with the Louisiana Department of Health in order to fund supplemental payments for services provided by physicians, physician assistants, certified registered nurse anesthetists and certified registered nurse practitioners pursuant to the approved state plan amendment TN #17-0011.

Indemnity

I certify that _____ [Governmental Facility to IGT] understands that LDH intends to use transferred funds as the state's share in claiming Federal Financial Participation ("FFP") for use in the program and agrees that in transferring institutional funds to LDH,

I certify that any funds transferred by _____ [Governmental Facility to IGT] are Public Funds, as described in 42 C.F.R. 433.51 and are not disqualified for use as the state's share in claiming FFP, such as provider-related donations, non-allowable health care-related taxes, and non-allowable Federal funds.

I further certify that should any portion of the transferred funds be discovered to not be permissible as the state's share in claiming FFP, whether before or after such use for this purpose, _____ [Governmental Facility], along with _____ [Governmental Facility that will complete IGT if different], agree to defend, indemnify, and hold LDH harmless for any loss that results from the use of such funds as the state's share in claiming FFP.

I further certify that _____ [Governmental Facility], along with _____[Governmental Facility that will complete IGT if different], will hold LDH harmless and indemnify LDH for any claims, losses, or damages arising out of payments made to _____ [Governmental Facility] or to Practitioner Group under approved state plan amendment TN #17-0011.

Witness	[Name] [Title] [Governmental Facility – Qualifying Entity]
Witness	[Name] [Title] [Governmental Facility – Completing IGT (if different than above)]

SWORN AND SUBSCRIBED BEFORE ME, the undersigned Notary Public, on this _____ day of _____, Year_____, at _____, Louisiana.

Notary Public

#124637

Attach listing in the following format:

Medicaid Provider Billing IDs (Group IDs only) included in Certification:

Billing ID
1234567
8910111