Certification of Funds Form

All information on this form is required. If you have any questions or require further assistance regarding certification of public expenditures (CPEs), please call the TMHP Contact Center at 1-800-925-9126 or visit TMHP.com.

A. Provider Information

National Provider Identifier (NPI):		
Texas Provider Identifier (TPI):		
Provider Name:		Date:
Street Address or P.O. Box:		Suite or Apt. No.:
City:	State:	ZIP Code:
Telephone:	Fax:	Email:

B. Provider Certification Statement

By signing below, I confirm:

1. I have examined this statement and the provider's supporting documentation of Medicaid-allowable expenses and services from its books and records for the dates of service (_____ to _____) covered by Medicaid payments received during the quarter covered by this letter, and certify to the best of my knowledge and belief that it is a true and correct statement.

2. The payments included in this statement under "Federal Share" reflect payments made based on actual services rendered. If required by the Texas Medicaid State Plan for services delivered by the provider, these payments will be reconciled to actual costs through the cost reporting, cost reconciliation, and cost settlement processes.

3. Medicaid-allowable state/local funds in an amount equal to or greater than the amount reported under "Total Computable Expenditure" were available and used to pay for Medicaid-allowable costs covered by the amount reported under "Total Computable Expenditure" and such state/local funds were in accordance with all applicable federal requirements for the nonfederal share match of expenditures.

4. Federal matching funds are not being claimed on this report to match any expenditure under any federal state plan that was submitted after January 2, 2001, and that has not been approved by the Secretary of Health and Human Services effective for the services covered by this letter.

5. I am the business officer or financial representative of the provider authorized by the provider to sign and submit this form.

6. I understand that Medicaid payments for the services delivered by the provider and documented herein are from federal and state/local funds, and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.

_____ _____

Signature *(stamped signatures not accepted)* Date

Submit Form