OHIO MEDICAID'S ENCOUNTER DATA CERTIFICATION FORM

<DATE>
Office of Medical Assistance

RE: **<MCO>** Medicaid Managed Care Encounter Data Certification

On behalf of **<MCO>**, I attest, in accordance with 42 CFR 438.600 to 438.606, that, to the best of my knowledge, information and belief, all data submitted are complete, accurate and true and have been submitted in accordance with the contract between the MCO and the Ohio Department of Job and Family Services. I further attest that, to the best of my knowledge, no material fact has been omitted from the data form and acknowledge that the information described below may directly affect the reimbursement to the MCO that I represent. This statement applies to all documents and data submitted by the MCO to ODJFS, including, but not limited to, the following information: encounter data, claims data, financial data, and other workbook files.

Instructions: List the file name and number of claims for each encounter data file submitted. Provide the Claim Type (837I, 837P, 837D, or NCPDP), New-Day (N), Voids (V) and/or Replacements (R), and Plan Payment Date(s) (Month + Year) for each encounter data file submitted.

File Name	# Claims	N = New Day Claims V = Void Claims R = Replacement Claims (Indicate all that apply for each file)	Payment Date (Month/Year)	Claim Type: 837I 837P 837D or NCPDP	Date File Uploaded to Portal (Month/Day/Year)

Provide the data source contact information:

Name _____ Email _____ Phone number _____

Sincerely,

Signature (CEO/CFO/Delegate) _____ Please print or enter name _____ Title (CEO/CFO/Delegate) _____

NOTE: If Delegation is utilized it must be in writing. Delegate must be a direct report to the CEO/CFO. Person signing certification must be named in the written delegation provided to the Agency.