



MCBR Certification

14.0 Appendix I – MCBR Certification

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS OR OMITTS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO PENALTIES INCLUDING BUT NOT LIMITED TO FINE, IMPRISONMENT OR CIVIL MONEY PENALTIES UNDER STATE AND/OR FEDERAL LAWS.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying MCBR report prepared by:

Provider Name: _____

Provider NPI or DMAP Atypical Number: _____

Provider Taxonomy: _____

for the calendar quarter ended _____; and that it is true, correct and complete in accordance with applicable State and/or Federal laws, regulations, and instructions.

- There were no balances outstanding on close of business for calendar quarter ending _____.

Name of Provider Representative (PRINT)

Signature of Provider Representative

Title

Date

Name of Contact Person (PRINT) if different from representative above.

Telephone Number

Certification page and detail page must be submitted to:

Delaware Division of Medicaid & Medical Assistance
Medicaid Surveillance and Utilization Review Unit, James Williams State Service Center
3rd Floor
805 River Road
Dover DE 19901