



**Federally Qualified Health Center
Managed Care Accuracy Audit Report
MCE Attestation Statement**

MCE Information:

MCE Name: _____

MCE Medicaid ID Number: _____

Months under Review: _____

Year under Review: _____

Attestation by Officer or Administrator of the MCE:

I, the undersigned, hereby certify under penalty of perjury that as an official of the subject organization I am duly authorized to sign this attestation, and that to the best of my informed knowledge and belief the statements made herein and the documents attached hereto are accurate, true, and complete in all material aspects.

I understand that the Colorado Department of Health Care Policy and Financing is relying upon this attestation as part of its accuracy audit process, and that should it be determined that this attestation is materially false, incomplete, or incorrect, or that it includes incorrect, false, or misleading information, appropriate enforcement action will be taken.

In the case that the MCE has a contractual obligation with the Department to reimburse FQHCs at their full Medicaid encounter rates, and a Managed Care Accuracy Audit Report finds that a FQHC is due additional reimbursement from a MCE, I further understand that it is the responsibility of the subject MCE to pay the additional reimbursement to the subject FQHC within ninety (90) days of the Department's notification of the issue. In addition, I understand that this additional reimbursement will not be accounted for in the current capitation rate adjustment paid by the Department.

Signature: _____

Name: _____

Position/Title: _____

Email Address: _____

Phone Number: _____

Date: _____

HCPF Use Only

Report Submission Date: _____