1. I certify that the information on the reverse side of this form is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statements or documents, or concealment of a material fact will be prosecuted under applicable federal and state law. Payment has not been received from any other source, except as may be noted on reverse side, or as received from the client in the form of copayment.
2. I will accept, as payment in full, payment under the Colorado Medical Assistance Program and certify that no supplemental charges have been or will be billed to the patient except for any items or services that are not reimbursable under the Colorado Medical Assistance Program. I agree not to bill the patient for covered items and services that would have been reimbursable under the program, had I complied with the rules and regulations of the Colorado Medical Assistance Program.
3. Items and services provided by me are available without discrimination as to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, handicap, or national origin. I hereby certify compliance with Section 504 of the Rehabilitation Act of 1973 which provides that "no otherwise qualified handicapped individual… shall solely, by reason of his handicap, be excused from participation in, be denied the benefits of or be subjected to discrimination under any program or activity receiving federal financial assistance."
4. I agree to answer questions and to keep such records as are necessary to disclose the nature and extent of services provided to an individual under the State's Title XIX Plan. I will furnish information regarding such requests for payment on request of the U.S. Department of Health and Human Services and the Colorado State Department of Health Care Policy and Financing, the Medicaid Fraud Control Unit, or their representatives. All such records will be maintained for six (6) years unless an additional retention period is required under Department regulations or in a specific contract with the provider and will be subject to inspection by any of the above named agencies upon reasonable notice.
5. I certify that I am currently licensed by the appropriate state licensing agency in which these services were rendered, and that the items or services for which payment is requested are medically necessary or covered preventive services.
6. If the provider signing the claim form as the billing provider is not the provider of services, it is understood that there is an agreement between the provider and that person signing the claim form that:
    1. The provider has authorized the signature on the reverse side.
    2. The provider has filed with the Fiscal Agent the authorized signature.
    3. The provider takes full responsibility for the items, charges, or services submitted under the provider number.
7. CERTIFICATION STATEMENT APPLICABLE TO PHYSICIANS ONLY

    I certify that the services for which payment is requested were either rendered personally by me, or rendered by qualified personnel under my direct and personal supervision as defined by Department of Health Care Policy and Financing regulation 10CCR 2505-10, Section 8.201 which states:

    > "Direct and personal supervision, for purposes of contracting with a Medicaid provider, shall be defined to mean that a physician shall be physically present on the premises at the time the treatment is provided by the qualified non-physician provider, unless otherwise provided in these rules."
8. The provider and person signing this claim understand that failure to comply with any of the above in a true and accurate manner will result in any available administrative or judicial action available to the State Department of Health Care Policy and Financing or other government agencies. The knowing submission of false claims may subject the persons responsible to criminal charges, civil penalties, and forfeitures.