COLORADO
Department of Health Care Policy & Financing

Colorado Medical Assistance Program

Dental Provider Certification

This is to certify that the foregoing information is true, accurate, and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification or concealment of material fact may be prosecuted under Federal and State Laws.

Signature: _____ Date: _____

This document is an addendum to ADA Dental Claim forms, and this document is required per 42 C.F.R. 455.18 (a)(1-2) to be attached to dental claims that are submitted for payment by paper.