



Colorado Medical Assistance Program

Institutional 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 the UB-04 claim form and is required per 42 C.F.R. § 455.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.