

**15. Certification Statement**

This section is used to officially notify the provider of additional requirements that must be met and maintained in order for the provider to be enrolled in the Medicare program. This section also requires the signature and date signed of an "Authorized Official" who can legally and financially bind the provider to the laws, regulations, and program instructions of the Medicare program. Section 16 permits the "Authorized Official" to delegate signature authority to other individual(s) (Delegated Officials) employed by the provider for the purpose of reporting future changes to the provider's enrollment record. See instructions to determine who within the provider qualifies as an Authorized Official and a Delegated Official.

**A. Additional Requirements for Medicare Enrollment**

**By his/her signature(s), the authorized official named below and the delegated official(s) named in Section 16 agree to adhere to the following requirements stated in this Certification Statement:**

- 1.) I agree to notify the Medicare contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in the business structure of this provider may require the submission of a new application.
- 2.) I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing number(s), and/or the imposition of fines, civil damages, and/or imprisonment.
- 3.) I agree to abide by the Medicare laws, regulations, and program instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare contractor.
- 4.) Neither this provider, nor any 5% or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.
- 5.) I agree that any existing or future overpayment made to the provider by the Medicare program may be recouped by Medicare through the withholding of future payments.
- 6.) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
- 7.) I authorize the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or any other national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS), a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

**B. 1<sup>st</sup> Authorized Official Signature** ☐ Add ☐ Delete **Effective Date:** \_\_\_\_\_

**I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.**

Authorized Official Name	First	Middle	Last	Jr., Sr., etc.
<u>Print</u>				

Authorized Official	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Title/Position	Date (MM/DD/YYYY)
<u>Signature</u>			Signed

**C. 2<sup>nd</sup> Authorized Official Signature** ☐ Add ☐ Delete **Effective Date:** \_\_\_\_\_

**I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and I authorize the Medicare program contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.**

Authorized Official Name	First	Middle	Last	Jr., Sr., etc.
<u>Print</u>				

Authorized Official	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Title/Position	Date (MM/DD/YYYY)
<u>Signature</u>			Signed