

15. Certification Statement

This section is used to officially notify the supplier of additional requirements that must be met and maintained in order for the supplier 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 supplier 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 supplier for the purpose of reporting future changes to the supplier's enrollment record. See instructions to determine who qualifies as an authorized official and a delegated official for the supplier.

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 30 days of the effective date of the change. I understand that any change in the business structure of this supplier 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 applicable to DMEPOS suppliers. The Medicare laws, regulations, and program instructions are available through the Medicare contractor.
- 4.) Neither this DMEPOS supplier, 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 agency or 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 DMEPOS supplier 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.

B. 1st Authorized Official Signature ☐ Add ☐ Delete **Effective Date:** _____

I have read the contents of this application. My signature legally and financially binds this supplier 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. I also certify that I have read, understand, meet, and will continue to meet all supplier standards as outlined in 42 CFR § 424.57. 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 <u>Print</u>	First	Middle	Last	Jr., Sr., etc.
Authorized Official <u>Signature</u>	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Title/Position Signed

C. 2nd Authorized Official Signature ☐ Add ☐ Delete **Effective Date:** _____

I have read the contents of this application. My signature legally and financially binds this supplier 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. I also certify that I have read, understand, meet, and will continue to meet all supplier standards as outlined in 42 CFR § 424.57. 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 <u>Print</u>	First	Middle	Last	Jr., Sr., etc.
Authorized Official <u>Signature</u>	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Title/Position Signed