COLORADO
Department of Health Care Policy & Financing

Federally Qualified Health Center

Managed Care Accuracy Audit Report

FQHC Attestation Statement

FQHC Information:

FQHC Name: _____

FQHC Number(s): _____

Months under Review: October - December

Year under Review: 2016

Attestation by Officer or Administrator of the FQHC:

I, the undersigned, hereby certify under penalty of perjury that as an official of the subject facility I am duly authorized to sign this attestation, and that to the best of my informed knowledge and belief the statements made herein and the documents attached hereto are accurate, true, and complete in all material aspects.

I certify that the subject facility is a contracting provider with the Managed Care Entity(s) included in the documents attached, have received a Prior Authorization Agreement for the visits included in the documents attached, **or** these visits were for emergency services.

I attest that the number of visits included in this report are for valid visits during the time period in question. Valid visits are visits that have been adjudicated to paid status by the MCE, as well as conform to the following rules:

1. One visit should generate one and only one encounter. A medical visit, a dental visit, and a mental health visit on the same day and at a single location shall count as three separate encounters. However, multiple services with one or more health professionals that take place on the same day and at a single location - as well as fall under the same category of medical, dental, or mental health - constitute a single visit. See 10 CCR 2505-10 8.700.6.B. 2.
2. The services provided must be those allowed at a certified FQHC. See 10 CCR 2505-10 8.700.3.

I understand that the Colorado Department of Health Care Policy and Financing is relying upon this attestation as part of its accuracy audit process, and that should it be determined that this attestation is materially false, incomplete, or incorrect, or that it includes incorrect, false, or misleading information, appropriate enforcement action will be taken.

HCPF Use Only
Report Submission Date: _____

COLORADO
Department of Health Care Policy & Financing

Signature: _____

Name: _____

Position/Title: _____

Email Address: _____

Phone Number: _____

Date: _____

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