**ATTESTATION**

## TO BE COMPLETED BY AN AUTHORIZED AGENT OF PROVIDER ORGANIZATION

I hereby state and verify that the facts and information set forth in the foregoing Provider Self-Auditing Form are true and correct to the best of my knowledge, information and belief. I understand that any misleading statements or material omissions will result in an Event of Default under my Community Behavioral Health Provider Agreement and may result in partial or full termination of my in-network status with Community Behavioral Health. I also understand that the statements made in Provider Self-Auditing Form are subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

**Typed Name/Title/Date:** _____

**Signature/Title/Date:** _____

***Acceptance of payment by CBH does not constitute agreement as to the amount of loss suffered, or agreement regarding compliance with federal and state laws, regulations, and policies relating to the MA program.***

FOLLOWING THE COMPLETION OF THE SELF-AUDIT, SUBMIT THIS FORM TO THE CBH COMPLIANCE DEPARTMENT ALONG WITH THE CLAIMS OVERPAYMENT SPREADSHEET FOR ANY OVERPAYMENTS OR IMPROPER PAYMENTS THAT ARE TO BE PAID BACK TO CBH. RELEVANT SUPPORTING DOCUMENTATION MAY ALSO BE SUBMITTED (E. G. SCREEN SHOTS, DOCUMENTATION, ENCOUNTER FORMS).