



## Provider Certification

Provider Name: \_\_\_\_\_

Provider NPI or tax ID number: \_\_\_\_\_

By signing this statement, I, the provider representative, certify that I am responsible for the accuracy and completeness of all claims transmitted to MDCH by The Information Center, Inc. and their billing agent.

I acknowledge that my signature on this document to support submission of claims will indicate my organization's agreement to abide by the rules and regulations for all purposes related to Title XIX (Medicaid) reimbursement by the MDCH, including any administrative, civil and/or criminal action(s) relating to my participation in the Medicaid program. A lack of my Waiver Agent's or billing agent representative's signatures on claims made on my behalf shall not be used to avoid criminal and/or civil responsibility.

This document will be kept on file to certify expenditures submitted to The Information Center, Inc. for reimbursement, and for reference when bills are submitted.

Name (please print): \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

Attached is the certification letter that must be signed and returned to begin the process of posting bills on Vendor Billing. This letter will be kept on file and will serve as your electronic signature. You will be notified once you are authorized to begin posting on Vendor Billing. If you have any questions please contact Creista Dawson .

Please return the signed certification addressed as follows:

The Information Center, Inc.

Attention: Creista Dawson

20400 Superior Rd.

Taylor, MI 48180