EXHIBIT "J"
to Third Amended Complaint

U.S. ex rel. Williams v. Health Management Associates, Inc., Tenet Healthcare Corporation and Hispanic Medical Management d/b/a Clinica de la Mama, et al.

PART I
POLICIES
AND
PROCEDURES
FOR
MEDICAID/PEACHCARE FOR KIDS

Georgia Department of Community Health

Division of Medicaid

Revised: April 1, 2013

PREFACE

This manual contains basic information concerning Georgia's Medicaid/PeachCare for Kids program and is intended for use by all participating providers. Along with the Statement of Participation, this manual encompasses the terms and conditions for receipt of reimbursement.

We urge you and your office staff to familiarize yourself with the contents of this manual and refer to it when questions arise. Use of the manual will assist in the elimination of misunderstandings concerning the coverage levels, eligibility, and billing procedures that can result in delays in payment, incorrect payment, or denial of payment.

Amendments to this manual will be necessary from time to time due to changes in federal and state laws and the Department of Community Health (the Department), Division of Medicaid's (Division) policies and procedures. When such amendments are made, they will be posted at www.mmis.georgia.gov, which shall constitute formal notice to providers. The amended provisions will be effective on the date of the notice or as specified by the notice itself, and all providers are responsible for complying with the amended manual provisions as of their effective dates.

Thank you for your participation and interest in Georgia's Medicaid/PeachCare for Kids program. Your service is greatly appreciated.

Rev. 01/06 **106. General Conditions of Participation**

As general conditions of participation, all enrolled providers must:

A) Be fully licensed without restriction and certified under all applicable state and federal laws to perform the services in the applicable category of service, maintain current (non-delinquent) licenses and certifications required for the provision of such services, and inform the Division in writing immediately upon the expiration, suspension, probation, limitation or revocation of any such license or certification.

Rev. 10/04

Rev. 01/06

Rev. 04/05

1) A restriction shall be defined as:
   - A public reprimand;
   - Any period of probation, regardless of whether said period of probation is subject to terms and conditions;
   - The requirement of compliance with any terms and conditions, as administered by any licensing board, such that said compliance would allow the provider to practice in his or her trade;
   - A suspension of any license for any period;
   - A limit or restriction on any license, including, but not limited to, monitoring of the provider's work by a another professional and/or the submission of reports detailing job performance or mental/physical fitness for duty to any entity (a provisional license issued during license application is not considered a restriction for a home health provider);
   - A license revocation;
   - The application of a penalty or the withholding of formal disposition based upon the provider's submission to the care, counseling, or treatment of physicians or other professional persons, and the completion of such care, counseling or treatment.

Rev. 01/06

Rev. 07/05

Rev. 04/05

2) As licensure relates to the operation of personal care homes that meet a business need for the Department, an initial provisional license without restriction issued as part of the application process for a license to operate a personal care home shall not be considered a restriction.

Rev. 10/05

Rev. 01/06

3) Ensure that all licensed professional personnel providing services to members through a provider's number are fully licensed without restriction as defined in §106(A)(1). All licensed professional personnel must meet all standards for full licensure in their respective field.

B) Comply with all State and Federal laws and regulations related to furnishing Medicaid/PeachCare for Kids services.

C) Provide services in compliance with Title VI of the Civil Rights Act of 1964 as amended which provides that no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be

denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

D) Provide services in compliance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. Section 504 provide that no otherwise qualified handicapped individual shall solely by reason of his or her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

E) Not contact, provide gratuities or advertise "free" services to Medicaid or PeachCare for Kids members for the purpose of soliciting members' requests for services. Any activity such as obtaining a list of Medicaid or PeachCare for Kids members or canvassing neighborhoods for direct contact with Medicaid or PeachCare for Kids members is prohibited. Any offer or payment of remuneration, whether direct, indirect, overt, covert, in cash or in kind, in return for the referral of a Medicaid or PeachCare for Kids member is also prohibited. It is not the intent of this provision to interfere with the normal pattern of quality medical care that results in follow-up treatment. Direct contact of patients for follow-up visits is not considered solicitation, nor is an acknowledgment that the provider accepts Medicaid/PeachCare for Kids patients.

F) Allow Medicaid or PeachCare for Kids members the opportunity to choose freely among available enrolled providers. It is not the intent of this provision to preclude referrals to other enrolled providers when medically necessary.

G) Not engage in any act or omission that constitutes or results in over utilization of services.

H) Not intentionally or negligently damage or endanger the health, safety, or welfare of any Medicaid or PeachCare for Kids member.

Rev. 04/13

I) Not bill the Division for an amount greater than the lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date of service or accepted from other third party payers.

J) Neither bill the Division for any services not performed or delivered in accordance with all applicable policies, nor submit false or inaccurate information to the Division relating to provider costs, claims, or assigned certification numbers for services rendered.

K) Bill the Division for only those covered services that are medically necessary and within accepted professional standards of practice.

L) Accept responsibility for every claim submitted to the Division that bears the provider's name or Medicaid/PeachCare for Kids provider number. Submission of a claim by a provider or his agent, acceptance of a Remittance

Advice, or acceptance of claim payment constitutes verification that the services were performed by that provider (or under his direct supervision, if allowed by the Division) and that the provider authorized submission of the claim for reimbursement. Remittance Advices shall be deemed accepted if the provider does not notify the Division or its third party administrator to the contrary in writing within ninety (90) days after their issuance. Payments shall be deemed accepted when cashed, negotiated, or deposited, including those payments deposited electronically.

M) Refund any overpayments or Advance Payments to the Division within required time frames.

Rev. 07/04

N) Accept the Division's payment as payment-in-full for covered services to patients accepted as Medicaid or PeachCare for Kids members. In most cases, this does not prohibit the provider from receiving reimbursement for covered services from liable third parties or other insurance plan. See Section 303.5 for special rules that apply to tort cases.

O) Deduct all payments for covered services received from third parties or other insurance plans from the amount billed to the Division for covered service(s) rendered and notify the Division regarding the existence of any other insurance or third party resource unless billing for managed care co-payment.

P) Agree not to seek or accept any payment whatsoever for covered services from the member or other interested party when the member was accepted as a Medicaid or PeachCare for Kids member. However, they are required to pay a co-payment for some services received. Further, no deposit may be required from the member or other interested party pending receipt of Division payment.

Rev. 10/03

Rev. 04/13

Q) Not seek reimbursement from the member or other interested party from claims submitted to the Division for which payments subsequently are denied, reduced, recouped, or refunded due to the provider's failure to comply with Divisional policies and procedures (e.g., timely submission of claims, incorrect billing, determination that services were not medically necessary, etc.) or due to the provider's receipt of payment from a third party.

R) Maintain such written records for Medicaid/PeachCare for Kids members as necessary to disclose fully the extent of services provided and the medical necessity for the provision of such services, for a minimum of five (5) years after the date of service. Providers should ensure that member records are forwarded to a member's new provider during a change of ownership, voluntary or involuntary termination, transfer of a member to a new provider or any other action that requires the review of member records to determine course of treatment. Member records must, at a minimum, reflect the date of service, member name and medical history, the service provided, the diagnosis and the prescribed drugs or treatment ordered, and the signature of

Rev. 10/04

Rev. 10/06

Rev. 01/08

the treating provider. **The Department will accept secure electronic signatures as defined in the Definitions section of this Manual. Please refer to Part II for more stringent documentation and secure electronic signature requirements applicable to different categories of service.**

Rev. 10/04

S) Comply in a timely fashion with all requests for records, information, and documentation made by the Division, its authorized representatives and agents, and the Secretary of the U.S. Department of Health and Human Services, related to services provided under the Medicaid/PeachCare for Kids Program. No fee can be charged to the Division by the provider for records, information and/or documentation requested by the Division, its agents or the Department of Health and Human Services.

Rev. 10/04

T) Make available for on-site audits by the Division or its agents all records related to services for which claims are submitted to the Division (including private-pay invoices, other insurance remittance advices, denial letters and explanation of benefits for members with other insurance). Providers using computerized information systems for accounting or other purposes must make this information available in a suitable electronic format if requested by the Division or its agents. No fee can be charged to the Division by the provider for records, information and/or documentation requested by the Division, its agents or the Department of Health and Human Services.

Rev. 04/05

U) Adhere to all the applicable policies and procedures of the Department.

V) Not have been terminated from or refused enrollment by the Division in the Medical Assistance Program within one year prior to the date of application, or within a period otherwise specified by the Division.

Rev. 10/04
Rev. 04/07
Rev. 07/11
Rev. 04/09

W) **Not employ or contract with a person, provider, owner, managing employee, partnership, or corporation previously terminated or suspended from the Program, barred from enrollment, previously or currently placed on the Department of Health and Human Services, Office of the Inspector General's sanction or exclusions lists, General Service Administration's Excluded Parties List System (EPLS), the Social Security Administration's Death Master File or a person, owner, managing employee, partnership, or corporation that has ever been convicted of any offense as described in §404(J) of this Manual.** Medicaid payments cannot be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. (42 CFR Section 1001.19019(b)). The exclusion includes administrators, billing agents, accountants, claims processors or utilization reviewers that are related to and reimbursed, directly or indirectly by a Medicaid program. Providers can

Rev. 07/11

search by individual names or entity name on the HHS-OIG, EPLS, and the Social Security Administration's Death Master File websites. Providers are required to search the HHS-OIG and EPLS websites monthly to capture exclusions and reinstatements that have occurred since the last search. Providers are required to report to the Department of Community Health Provider Enrollment Section immediately any exclusion information discovered among employees or contractors.

Rev. 07/05

Rev. 07/11

X) The Provider, owner, and managing employee cannot appear on the Department of Health and Human Services, Office of the Inspector General's (OIG) Exclusion List, General Service Administration's Excluded parties List System (EPLS), and the Social Security Administration's Death Master File. Providers required to have a NPI number must appear on the National Plan and Provider Enumeration System (NPPES).

Y) Provide services in compliance with the Age Discrimination Act of 1975 as regulated by 45 CFR, Part 91 which provides that "no person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Z) Furnish to the Division and to the Secretary of the U.S. Department of Health and Human Services, within thirty-five (35) days of the date of a request, full and complete information about the ownership of any subcontractor with whom the provider had business transactions totaling more than Twenty-Five Thousand Dollars ($25,000) during the twelve (12) month period ending on the date of the request, and any significant business transactions between the provider and wholly-owned supplier, or between the provider and any subcontractor, during the five (5) year period ending on the date of the request.

AA) Disclose fully and accurately to the Division, prior to execution or renewal of a Statement of Participation or upon written request by the Division, the identity of any person who has ownership or controlling interest in the provider organization or is an agent or managing employee of the provider and their criminal history, if any.

BB) Furnish services to a member regardless of a third party's potential liability for payment for the service.

Rev. 10/12

CC) Not bill or otherwise seek reimbursement from the member or other interested party for missed appointments, claims preparation, completion of forms, telephone consultations, after hours surcharges, reading or interpreting reports, supplying supporting documentation to the Division or its Third party administrator, or forwarding copies of a patient's medical records one time to other providers when requested by the patient or the patient's chosen provider. If a patient requests a provider to forward medical

records more than one time, the provider may charge the patient a reasonable cost for making the copies, not to exceed ten dollars ($10.00).

DD) Refund to the Division any prescription drug rebates obtained by the provider for prescription drugs furnished to members.

Rev 07/05

EE) Maintain current contracts with other State agencies if said contracts are necessary to continue operations.

Rev. 04/06

Rev. 10/06

FF) **Not alter patient records, even in an effort to correct an error. All errors shall be corrected according to currently accepted standards of medical practice (corrections shall evidence the error, the correction, the initials of the corrector and the date of the correction). Failure to comply with medical records requirements will subject providers to recoupment of payment.** ***See*** **§405.**

Rev. 10/06
Rev. 04/07

GG) **Register your National Provider Identifier with the Department prior to May 23, 2007.**

Rev. 01/08

HH) Be responsible for the integrity and accuracy of its representations and the Division may reasonably rely upon the representations and certifications made by the Provider, without first making an independent investigation or verification.

Rev. 01/08

II) Be responsible for the integrity and accuracy of its audit reports, summaries, analyses, certifications, reviews, and work products and the Division may reasonable rely upon any audit report, summary, analysis, certification, review, or work product that the provider produces in accordance with its duties under its Statement of Participation, without first making an independent investigation or verification.

Rev. 01/08

JJ) Not employ, contract, or partner with any person employed with the Department or with any person employed by a subcontractor or vendor of the Department.

Rev. 01/08

KK) Comply with the Privacy Rule and the Security Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as set forth in federal regulations at 45 C.F.R. Parts 160 and 164, and maintain administrative, physical and technical safeguards of protected health information.

Rev. 07/11

LL) Consent to criminal background checks including fingerprinting.

Rev. 04/13

MM) Not intentionally or knowingly order, refer, or prescribe and item and/or service that allows a false or fraudulent claim to be presented for payment by Medicaid.

Rev. 04/07

106.1 Compliance with 42 U.S.C. §1396(a) (68)

Rev. 01/08

Rev. 07/08

As further terms and conditions of participation, and in compliance with 42 U.S.C. §1396(a)(68), all entities that receive annual Medicaid payments of at least $5 million shall, as a condition of receiving such payments, establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in 42 U.S.C. §1396(a)(68)(A). **The entity must provide copies of its written policies to its employees (including management), and to any of its contractors and agents that perform billing or coding functions for the entity, or that furnish or authorize the furnishing of Medicaid health care items or services on behalf of the entity, or that are involved in monitoring of health care provided by the entity.**

The entity's written policies and procedures must contain detailed information about the Federal laws identified in Section 6032(A) and about Georgia's laws imposing civil or criminal penalties for false claims and statements, and about whistleblower protections under such laws as found in the State False Medicaid Claims Act, Article 7B of Chapter 4 of Title 49 of the Official Code of Georgia.

The entity's written policies and procedures must also contain detailed information regarding its own policies and procedures to detect and prevent fraud, waste and abuse in Federal health care programs, including the Medicare and Medicaid Programs. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents.

The entity's written policies and procedures must be included in any employee handbook maintained by the entity. The entity need not create an employee handbook if one already exists.

Rev. 01/08

Affected entities shall execute an Attestation of Compliance (Appendix K) that will be maintained with the Department. Affected entities are those that meet the $5,000,000 annual threshold as measured from October 1 through September 30 of the previous Federal fiscal year.

As further explanation, please note the following:

1) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of

business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

2) An "employee" includes any officer or employee of the entity.

3) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

4) If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

5) A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

Rev. 07/08

6) An entity will have met the $5,000,000 annual threshold as of January 1, 2008, if it received or made payments in that amount in Federal fiscal year 2006 (October 1 to September 30). Future submissions of the Attestation based upon an entity's responsibility stemming from the requirements of section 1902(a)(68) are due by December 31 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year. Entities meeting such criteria must submit their completed Attestation (Appendix K) and submit them to:

Department of Community Health
Legal Services Section
2 Peachtree Street
40th Floor
Atlanta, Georgia 30303

NOTE: Initial Attestations are due on July 15, 2008.

Subsequent yearly submissions are due December 31

Rev 04/08

106.2 Georgia Tamper-Resistant Prescription Pad Program

1) **As further terms and condition of participation, the Georgia Medicaid Fee-For-Service (FFS) Outpatient Pharmacy Program in accordance with Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, and in an attempt to combat fraud and abuse, will require prescribers to use tamper-resistant prescription pads for any new prescription with fill dates on and after April 1, 2008. This requirement applies to hard copy prescription orders for any drug, device or product covered through the Medicaid FFS outpatient pharmacy program whether legend or over-the-counter. Prescribers should review their Part II, Policies and Procedures manuals for any additional requirements.**

2) **Effective April 1, 2008, a prescription pad must contain at least one of the following three characteristics:**

• **Required tamper-resistant characteristics include one or more industry-recognized features designed to:**		• **Examples include but are not limited to:**
• 1	• Prevent unauthorized copying of a completed or blank prescription form	• **High security watermark on reverse side of blank** • **Thermochromic ink technology** • **Copied prescription blanks show the word "Copy," "Illegal," or "Void."**
• 2	• Prevent erasure or modification of information written on the prescription by the prescriber	• **Tamper-resistant background ink shows erasures or attempts to change written information**
• 3	• Prevent the use of counterfeit prescription forms	• **Duplicate or triplicate blanks**

3) **Beginning April 1, 2008, any pharmacist receiving a hard copy prescription not written on a tamper-resistant prescription blank for**

a Medicaid recipient subject to this rule must verify the prescription order with the prescriber's office by handwriting on the face of the original prescription the name of the person contacted at the prescriber's office, the date verified, the initials or name of the pharmacist or licensed pharmacy intern who verified the prescription, and the word "Verified".

4) **In circumstances of other insurance coverage in addition to Medicaid, tamper-resistant prescription pads are required regardless of whether Medicaid FFS is the primary or subsequent payer.**

5) **A prescription order written on a tamper-resistant prescription blank does not automatically make the prescription order compliant or valid. The pharmacist must exercise professional judgment and take appropriate measures necessary to ensure the validity and integrity of any prescription received. As always, the pharmacist must comply with all Medicaid Policies, as well as, all laws and regulations applicable to the practice of pharmacy.**

6) **Effective for dates of service on and after October 1, 2008, all prescription pads utilized for Medicaid FFS member prescriptions must comply with all three of the characteristics in the table above.**

7) **A prescriber's or pharmacy's routine failure (as determined by the Division) to comply with the requirements of this term and condition of participation will subject it to sanctions up to and including termination from the Medicaid/PeachCare for Kids programs.**

Rev 01/06

107. Member Eligibility

The Division establishes eligibility criteria for Medicaid/PeachCare for Kids benefits based upon federal regulations. Eligibility criteria for major coverage groups are identified in Appendix B.

107.1 Verification of Eligibility

Rev. 07/03
Rev.01/11

It is the responsibility of the provider to verify Medicaid/PeachCare for Kids eligibility on each date of service.

Though members will be issued Medicaid/PeachCare for Kids identification cards (See Appendix C) which should be presented, providers must verify eligibility by contacting the Provider Contact Center at (770) 325-9600 or 1-800-766-4456 or by conducting a member eligibility verification on the third party administrator's website at www.mmis.georgia.gov. Providers may request verification either

individually or in batch by submitting a HIPAA-compliant transaction, or by submitting a written request for eligibility verification to:

HP Enterprises
P.O. Box 105200
Tucker, Georgia 30085-5200

Written requests for eligibility verification must include the patient's full name, social security number if available, Medicaid/PeachCare for Kids number if available, home address, date of birth, gender, and date of service for which verification is sought.

Providers may also submit electronic requests for eligibility verification through their clearinghouse to the third party administrator's EDI gateway. More information about this submission may be obtained by contacting the EDI Unit at: 1-800-987-6715 or **www.mmis.georgia.gov**.

Providers may also confirm a member's Primary Care Provider through the Provider Contact Center, the third party administrator's website (www.mmis.georgia.gov) or eligibility vendors who provide access to eligibility information through the magnetic swipe and readers on the member identification cards.

Rev 07/05

Providers are barred from accepting Medicaid members if the Provider is not willing to accept a member who has been issued a temporary Medicaid card.

Rev. 10/06

PLEASE NOTE THAT THE DIVISION DOES NOT GUARANTEE PAYMENT UNLESS THE PATIENT IS ACTUALLY ELIGIBLE AND FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE.

107.2 Verification of Eligibility for Disproportionate Share Hospitals

The Division facilitates Medicaid/PeachCare for Kids eligibility verification for the benefit of hospitals that serve a disproportionate share of low-income patients. The disproportionate share hospital (DSH) may access this verification service as provided in this policy. In order to enable DSH providers to efficiently access the extensive data necessary for this verification, the Division provides data access only through appropriately qualified contractors. The selection of contractors who will be authorized to provide the data will be based upon considerations that include whether:

A) The proposed service is consistent with the relevant goals and objectives of the Medicaid/PeachCare for Kids program.

B) The disproportionate share hospitals in the proposed market to be served have a need for the service.

C) Existing alternative access to the necessary eligibility verification by the DSH providers to be served is not cost efficient for those providers.

D) The service is reasonably financially and physically accessible to the DSH providers.

E) The proposed service fosters overall improvement in the system of reimbursement for health care services without a loss of quality of care.

F) The contractors are bound by the terms of a contract with DCH for eligibility verification services and by applicable laws and regulations, particularly those provisions governing confidentiality and privacy of information.

Providers may also submit electronic eligibility verification requests on the web through the department's third party administrator's website at www.mmis.georgia.gov. Batch eligibility requests can be submitted through the web in a HIPAA-compliant format. For more information, providers may contact the third party administrator's EDI gateway at 1-800-987-6715.

Rev 01/06

108. Premium Payment and Continued Coverage

Some Medicaid/PeachCare for Kids services require members to pay premiums. Unless stated to the contrary in Part II, premiums are due and payable on the first day of the month preceding the month of coverage (i.e. April 1st for May coverage). Late payment of premiums could result in a break in coverage. Premium amounts for different programs and the effect of their untimely payment are described in Appendix D.

Rev 01/06

109. Limitations on Member Services

The Division has developed certain service limitations in an attempt to deter members' over-utilization of services (e.g., office visits, prescriptions, examinations, etc.). Please refer to Part II for limitation information applicable to different categories of service. Inquires related to a member's utilization history should be directed to the Provider Contact Center by dialing 1-800-766-4456. Data provided will be for informational purposes only and should not be regarded as official records upon which reimbursement relies. The Division is not responsible for the payment of services exceeding any monthly, annual, or other period limitation.

109.1 Member Lock-In

Rev. 04/05
Rev. 01/10

APPENDIX I
PHYSICIAN'S STATEMENT
FOR
EMERGENCY MEDICAL ASSISTANCE

Patient's Name: _____ DOB: _____
Patient's Address: _____

_____

Patient's Telephone #: _____

Individuals who do not meet Medicaid citizenship/alienage requirements may be eligible for Emergency Medical Assistance (EMA). EMA provides payment for the treatment of emergency when such care and services are necessary for the treatment of an emergency medical condition of the alien, provided such care and services are not related to either an organ transplant procedure or routine prenatal or postpartum care. An emergency is defined as:

"**Acute symptoms**" of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part"

The individual will have to be determined eligible for Emergency Medical Assistance under one of the Department's existing regular Medicaid coverage groups:

- Aged, blind or disabled;
- Pregnant women;
- Children under 19 years of age; or
- Parents in families with very low income

This form should be completed and signed by the provider after the Emergency has occurred. Forms containing future dates of service are invalid.

I provided EMERGENCY medical services on _____ through
(Date of onset)
_____ for the individual listed above.
(Not to exceed 30 days from condition onset date)

_____ _____
(Provider's Name) (Provider or Authorized Designee's Signature)

_____ _____
(Provider's Address) (Date)

DMA – Form 526 (Revised December 2005) Rev. 04/07

APPENDIX K

Attestation of Compliance
Section 6032 of the Federal Deficit Reduction Act (DRA)

Covered Entity: _____

Address: _____

Provider # _____ FEIN _____

Compliance Period: Calendar Year beginning January 1, ____.

I hereby attest that, as a condition for the above-identified Covered Entity to receive payments under the Georgia Medicaid/PeachCare for Kids Program, I have read Section 6032 of the Deficit Reduction Act of 2005 (the Act) and confirm that:

- The Covered Entity's written policies and procedures contain detailed information about the Federal laws identified in Section 6032(A) and about Georgia's laws imposing civil or criminal penalties for false claims and statements, and about whistleblower protections under such laws as found in the State False Medicaid Claims Act, Article 7B of Chapter 4 of Title 49 of the Official Code of Georgia; and

- The Covered Entity's written policies and procedures also contain detailed information regarding its own policies and procedures to detect and prevent fraud, waste and abuse in Federal health care programs, including the Medicare and Medicaid Programs; and

- The Covered Entity provides copies of its written policies to its employees (including management), and to any of its contractors and agents that perform billing or coding functions for the Covered Entity, or that furnish or authorize the furnishing of Medicaid health care items or services on behalf of the Covered Entity, or that are involved in monitoring of health care provided by the Covered Entity; and

- The Covered Entity's written policies and procedures are included in any employee handbook maintained by the Covered Entity.

I also confirm that the Covered Entity includes the Georgia Medicaid/PeachCare for Kids provider(s) identified on Attachment A.

I possess all necessary powers and authority to execute and make the representations contained in the Attestation of Compliance on behalf of the Covered Entity and any Georgia Medicaid/PeachCare for Kids provider identified on Attachment A.

_____ _____
Signature Date

_____
Print or Type Name and Title

ATTACHMENT A

Identification of Georgia Medicaid/Peachcare for Kids Providers

The Covered Entity identified in the ***Attestation of Compliance with Section 6032 of the Federal Deficit Reduction Act*** includes the following Georgia Medicaid/PeachCare for Kids Providers:

NAME	ADDRESS	Provider ID	FEIN