



Mandatory Compliance Program Obligation Attestation

According to the contract(s) between EmblemHealth and **(Provider name)** _____ (hereafter referred to as “the provider”), the provider agrees that if he/she is subject to the New York State mandatory compliance program, he/she will certify their program(s) with the New York State Office of Medicaid Inspector General (OMIG).

EmblemHealth is requesting the following attestation and evidence of OMIG certification. It confirms:

- The provider is or is not subject to the mandatory compliance program requirement.
- If the provider **is** subject to the mandatory compliance program requirement, he/she has completed the requisite annual certification.

Please complete the applicable attestation section below.

Providers subject to the mandatory compliance program requirement

I, **[Name, title, department]** _____,

do hereby certify that **(Provider name)** _____

claims, orders, or is paid \$500,000.00 or more per year from the Medical Assistance Program, including, in the aggregate, claims submitted to or paid directly by the Medical Assistance Program and/or claims submitted to or paid by any managed care organization (MCO) under the Medicaid managed care program, and therefore have adopted and implemented a compliance program which meets the requirements of New York State Social Services Law § 363-d(2) and 18 NYCRR § 521.3.

I, **[Name, title, department]** _____,

do hereby certify that **(Provider name)** _____

has certified to the New York State Department of Health, using a form provided by OMIG on its website, within 30 days of entering into a Provider Agreement with the managed care organization (MCO), if they have not so certified within the past year that a compliance program meeting the requirements of 18 NYCRR § 521.3 and Social Services Law § 363-d(2) is in place, and shall recertify during the month of December each year thereafter using a form provided by OMIG on its website.

Providers not subject to the mandatory compliance program requirement

I, **[Name, title, department]** _____,

do hereby certify that **(Provider name)** _____

does not claim, order, or is paid \$500,000.00 or more per year from the Medical Assistance Program, including, in the aggregate, claims submitted to or paid directly by the Medical Assistance Program and/or claims submitted to or paid by any managed care organization (MCO) under the Medicaid managed care program.

Signature

Date signed