

**SOUTHEASTERN REGIONAL MH/DD/SAS**

Provider Certification of Units

Date: \_\_\_\_\_

Organization Name: \_\_\_\_\_

Facility Name (physical location): \_\_\_\_\_ Billing Number: \_\_\_\_\_

Total Amount Billed: \_\_\_\_\_ (MCD/IPRS Rate)

Dates of Service: from \_\_\_\_\_ to \_\_\_\_\_

I certify that all units of service reported on the electronic invoice submitted on \_\_\_\_\_ to Southeastern Regional MH/DD/SAS for billing and reimbursement have incurred in connection with official duties of the provider as specified in the Southeastern Regional MH/DD/SAS contract. I certify that these units of service are documented in the provider records. I certify that all units reported and supporting documentation has been reviewed by the contractee as part of its monitoring process and are true and correct. The provider agrees and understands that, notwithstanding any approval by Southeastern Regional MH/DD/SAS for the invoice, pursuant to the prompt pay provision, if it is subsequently determined that the invoice(s) is incorrect, inaccurate, or does not reflect the services actually provided, Southeastern Regional MH/DD/SAS shall be entitled to receive from the Provider, within 30 days of notice to the Provider, any and all payments made to the Provider by Southeastern Regional MH/DD/SAS that were the result of an incorrect or inaccurate invoice(s). In addition, if as a result of the Provider's failure to comply with the applicable laws or Southeastern Regional MH/DD/SAS contract, or by reason of error, misfeasance or malfeasance, services provided by the provider are disallowed or rejected by Medicaid or the State of North Carolina, the Provider agrees to reimburse Southeastern Regional MH/DD/SAS for all funds not reimbursed for said services, also within 30 days.

Provider Authorized Signature: \_\_\_\_\_

Contact Person \_\_\_\_\_ Contact Phone Number \_\_\_\_\_

This form can be faxed to April Parker at (910) 272-9397 or scanned and attached to the electronic transmission of invoice.

