QUEST HAWAIʻI

More Choices For Your Healthcare

MYERS AND STAUFFER LC

CERTIFIED PUBLIC ACCOUNTANTS

PROVIDER SUPPLEMENTAL CERTIFICATION STATEMENT

Provider / Facility Name: ______________________________

Address Line 1: ______________________________

Address Line 2: ______________________________

City, State, Zip Code: ______________________________

Provider Number (NPI): ______________________________

The following certification is to be completed by the provider's Chief Executive Officer (CEO) or Chief Financial Officer (CFO) or Designee:

I certify that, to the best of my knowledge, the information submitted is true and accurate to the best of my ability, and supported by our financial and other records of the provider referenced above. I understand that this information will be used as part of the Medicaid credit balance analysis being performed by the Hawaii Medicaid Recovery Audit Contractor (RAC), Myers and Stauffer LC. Detailed support exists for all amounts reported on Addendum A (Credit Balance Report Form). These records will be made available for inspection when requested.

CEO/CFO/Designee Signature: ______________________________

CEO/CFO/Designee (PRINTED): ______________________________

CEO/CFO/Designee Title: ______________________________

CEO/CFO/Designee Phone Number: ______________________________

CEO/CFO/Designee E-mail Address: ______________________________

Date: ______________________________