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| --- | --- | --- |
| Vendor Name | |  |
| Vendor # | |  |
|  | | |
| This form must be completed and submitted along with each claim for Lag Payments to certify/attest to the following, consistent with the previously signed Lag Funding Agreement. Attestation to only one of the first two statements is required. | | |
| □ | Claims have been submitted to the applicable Managed Care Plan(s) (MCP) at least 30 days prior to this request for Lag Payments from the regional center and payment has not been received from the MCP(s) **OR,** | |
| □ | Due to factors beyond the Provider’s control, Provider has been unable to submit, or been delayed in the submission of, claims to the applicable MCP(s) for services provided at least 30 days prior to this request for Lag Payments. | |
| □ | Provider agrees to actively pursue/take steps necessary to obtain reimbursement from all applicable MCP(s). | |
| □ | Provider agrees to repay the regional center within 15 days of receipt of payment from the applicable MCP(s). | |
|  | | |

By the signing this form, the individual confirms they are authorized to certify/attest to the statements above.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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