

**REPORT D2:
DATA CERTIFICATION FORM¹**

Name of MHO: _____

MHO Plan Number: _____

Date or Week Ending: _____

Contractor must submit this report with each Encounter data submission.

Total Claim Count		Total Billed Amount	
------------------------------	--	----------------------------	--

Authorized Signature

Name (please print)

Title

Date

¹ If Contractor has the ability to send an "electronic signature document", please contact the DHS Encounter Data Liaison.