***Attestation for Automated Medicare***

***Crossover Claims Process***

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| Coordinated Care Organization (Contractor) Name: | |
| Medicaid Contract Number: |

I, the undersigned (as CEO, CFO of Contractor, or delegate of CEO/CFO), hereby certify based on best knowledge, information, and belief that all of the following are true and accurate:

1. As required by Exhibit B, Part 8, Section 6, Paragraph d of the Contract, Contractor has an automated crossover claims process in place for its Affiliated Medicare Advantage (MA) and Dual Special Needs Plans, which are listed below; and
2. Any Subcontractor(s), including risk-accepting entities, to which Contractor has delegated responsibility for claims processing has an automated crossover claims process in place for Contractor’s Full Benefit Dual Eligible Members. The MA and Dual Special Needs Plans affiliated with any such Subcontractor(s) are listed below.

**CONTRACTOR**

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|  | |  |  |  |  |
| Name | |  | Signature |  | Date |
| *Authority for above signer:* | Chief Executive Officer, | | | | |
| Chief Financial Officer, or | | | | |
| Delegate authorized by Delegation Authorization and Signature Form | | | | |

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| ***Name of each MA or Dual Special Needs Plan*** |
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