

**ANNUAL STOP-LOSS ATTESTATION STATEMENT**  
**For the period of January 1, 20\_\_\_\_\_ through December 31, 20\_\_\_\_\_**

I, \_\_\_\_\_, have the authority to make this attestation legally binding on behalf of \_\_\_\_\_, [hereinafter "Plan"]

On behalf of the Plan, I hereby attest to the State of New York that satisfactory documentation, including proof of payment to providers for all claims for enrollees submitted for Stop-Loss re-insurance submission, will be provided upon request or pursuant to any audit or other inquiry conducted by the State of New York to verify the appropriateness of the Stop-Loss payment.

Documentation

Documentation includes, but is not limited to: date(s) of service; verification that recipient was enrolled in the plan during all dates of service, all applicable medical records, patient diagnoses, service provider name(s) and identification number(s); and, proof of amount(s) actually paid to the service provider(s). Such amount(s) must be consistent with the terms of the contract between the local social services district and the plan or in the absence of specific contract term, then based on specific plan/provider contract terms, or shown to be the amount customarily paid by the plan for the service(s). Documentation must be accompanied by a cover sheet that details the submitted claim and the amounts used to calculate the claim total. The cover sheet must include: Plan Name and Medicaid ID # Enrollee Name - Enrollee ID# Benefit Year Applicable Stop-Loss Threshold Total Amount Over Threshold Less: Any Applicable Plan Liability and Third-party Payments. Please specify (e.g., co-payments and other insurance coverage): Net Amount of Stop-Loss Payment Due Plan Documentation requirements may be modified upon notice to the Plan and any other specific information that is or should be in the possession of the Plan must be provided upon request of the State of New York.

The Plan acknowledges that New York State has the right to recoup part or all of any monies paid by the State of New York to the Plan for Stop-Loss claims for inappropriate, incomplete or inaccurate or unavailable supporting documentation. The Plan ensures that all senior staff having pertinent responsibilities have read and are familiar with the New York State Medicaid Program's Managed Care Manual: Stop-Loss Policy and Procedure and all revisions thereto. The Plan can provide an appropriate staff member to attest that all claims are made in full compliance with the pertinent provisions of the Manual and revisions.

On behalf of the Plan, I attest that I have taken all reasonable measures to ensure that all information provided on this statement and the accompanying form(s) is true, accurate and complete to the best of my knowledge and that no material fact has been omitted. Furthermore, I attest that the Plan is due a Stop-Loss payment for identified enrollees and that this applies to all Stop-Loss claims submitted electronically or on paper, using the Plan's or my own NPI or Medicaid provider identification number. This attestation remains in effect and applies to all claims unless expressly superseded by another properly executed attestation statement.

Signature \_\_\_\_\_ Print/Type Name \_\_\_\_\_

Title \_\_\_\_\_ Name of Plan \_\_\_\_\_

State of \_\_\_\_\_ County Of \_\_\_\_\_

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_, before me personally came \_\_\_\_\_, to me know and known to me to the individual described in and who executed the foregoing instrument, and (s) he acknowledge to me that (s) he executed the same.

[SEAL]

NOTARY PUBLIC \_\_\_\_\_