STATE OF NEW YORK
DEPARTMENT OF HEALTH
OPERATING PLAN AND PREMIUM PROPOSAL
CERTIFICATION STATEMENT

Name of Medicaid Prepayment Plan: _____

Medicaid Proposed Rate Period: Start: End:

MMIS Number: _____

Mailing Address: (Organization Name, Street, City, State, Zip Code)

_____

_____

_____

_____

Contact Person:

Name: _____

Title: _____

Telephone Number: (_____) - _____

Chief Executive Officer or Executive Director:

Name: _____

Title: _____

Telephone Number: (_____) - _____

FAX Number: (_____) - _____

Certification Statement:

We hereby affirm that the information in this premium rate application including all schedules and exhibits thereto, has been prepared in accordance with the most recent instructions of the New York State Health Department and to the best of our knowledge and belief is accurate and complete.

_____ _____

Signature, Executive Director Date

_____ _____

Signature, Actuary (if used) Date

_____

Name of Actuarial Firm