Print Form

Status:	As Filed (Provider Version)	X	Desk Reviewed	
	Revised Desk Reviewed		Field Audited	

DEPARTMENT OF HUMAN RESOURCES - DIVISION OF MEDICAL ASSISTANCE

2016 HOSPITAL BASED RURAL HEALTH CLINIC

1. Name and Address					
Name of Facility:					
Street or P.O. Box:					
City:		State:	NC	Zip:	
County:		Telephone No:			
2. Cost Reporting Period	From:		To:		

3. NPI Provider No.:	Medicaid Provider No.:	NPI Provider No.:	Medicaid Provider No.:

4. Type of Control	a. Voluntary Nonprofit		b. Proprietary		
	1. Corporation		3. Individual		
	2. Other (Specify)		4. Corporation		
			5. Partnership		
			6. Other (Specify)		Describe other
	c. Government				
	7. Federal		10. State		
	8. City/County		11. City		
	9. County		12. Other (Specify)		Describe other

5. If we have questions regarding the cost report, who should we contact?				6. If the Notice of Program Reimbursement Settlement should be mailed to other than the facility, please list the name and address.			
Name:				Name:			
Address:				Address:			
City:				City:		State	
State:		Zip Code		Zip Code:			
Contact Name:							
Telephone:							
E-Mail:							

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND STATE LAW.

CERTIFICATION STATEMENT

I HEREBY CERTIFY that I have read the above statement and examined the accompanying schedules prepared by _____ for the cost report period beginning _____

(Name of Facility)

and ending _____ and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the facility in accordance with applicable instructions, except as noted.

Signature _____

(Officer or Administrator)

Title _____

Date _____