Physician Upper Payment Limit (UPL) Supplemental Payment Physician Practice Attestation Statement

I, _____(*print name*), _____(*print title*) of _____(*print name of physician practice*), _____ (*print Medicaid provider ID number of physician practice*) (hereinafter referred to as the "physician practice") am authorized by virtue of my position to speak on behalf of the physician practice.

I attest that the physician practice is enrolled in Georgia Medicaid and affiliated with a public teaching hospital enrolled in Georgia Medicaid. For purposes of physician UPL supplemental payments, a teaching hospital is defined as a hospital associated with an accredited medical school that offers clinical and other facilities to those studying to become physicians. An accredited medical school is defined as a medical school accredited by the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic College Accreditation. The physician practice's affiliated public teaching hospital is _____ (*print name of affiliated public teaching hospital*), _____ (*print Medicaid provider ID number of public teaching hospital*).

I attest that the physician practice has obtained a commitment from a Hospital Authority, or other government body, to make an intergovernmental transfer (IGT) of funds to DCH to finance the state share of the SFY 2017 supplemental payment to be made to the physician practice. The government body that has committed to make an IGT to finance the state share of the supplemental payment to be made to the physician practice is _____ (*print name of government body*).

Knowingly filing a false or fraudulent attestation statement with the Department of Community Health is a violation of state law punishable with up to $1,000 in fines and five years in prison.

_____	_____
Signature	Date
_____	_____
Print Name	Email Address
_____	_____
Print Title	Telephone Number

Physician Upper Payment Limit (UPL) Supplemental Payment Affiliated Public Teaching Hospital Attestation Statement

I, _____(*print name*), _____(*print title*) of _____(*print name of hospital*), _____ (*print Medicaid provider ID number of hospital*) (hereinafter referred to as the "hospital") am authorized by virtue of my position to speak on behalf of the hospital.

I attest that the hospital is enrolled in Georgia Medicaid, is a public teaching hospital, and is affiliated with _____ (*print name of physician practice*), _____ (*print Medicaid provider ID number of physician practice*). For purposes of physician UPL supplemental payments, a teaching hospital is defined as a hospital associated with an accredited medical school that offers clinical and other facilities to those studying to become physicians. An accredited medical school is defined as a medical school accredited by the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic College Accreditation.

Knowingly filing a false or fraudulent attestation statement with the Department of Community Health is a violation of state law punishable with up to $1,000 in fines and five years in prison.

_____	_____
Signature	Date
_____	_____
Print Name	Email Address
_____	_____
Print Title	Telephone Number