

Attestation of Application Fee Payment

Federal law generally requires some applicants for enrollment or reenrollment into a Medicaid program to pay an application fee. Provider types subject to the fee are:

- ICF-MR State Schools
- Acute In-Patient Hospitals
- Chronic In-Patient Hospitals
- Psychiatric In-Patient Hospitals
- Semi-Acute In-Patient Hospitals
- Skilled Nursing Facilities

All other providers are exempt from the fee. Providers who are required to pay the fee but enrolled in Medicare or another state's Medicaid or CHIP program, and have paid the application to the Medicare contractor or the other state's program, are also exempt. To claim this exemption, please complete this form and send it with your application, either as an attachment to your electronic application submission on the Provider Online Service Center (POSC) or with your paper application.

Please complete the following required information, check off the applicable Attestation Fee Payment box below, and then read and sign the attestation statement. Return this completed and signed form with your application.

Legal name: _____ Doing business as (DBA) name: _____

DBA address: _____

Application tracking number (ATN): _____

(The ATN is issued when the application is entered on the POSC or when an application is requested via MassHealth Customer Service.)

Tax ID no.: _____ NPI: _____

Contact name: _____ Phone: _____ e-Mail: _____

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- Applicant is enrolled in Medicare and has paid an application fee for this service location to the Medicare contractor.

Date paid: _____

Provide either the PECOS Payment Tracking ID or the pay.gov payment tracking ID: _____

- Applicant is enrolled in another state's Medicaid or Children's Health Insurance Program (CHIP) and has paid an application fee for this service location to another state's Medicaid or CHIP program.

Date paid: _____ State to which the application fee was paid: _____

Please attach confirmation of application fee payment.

Provide a contact name, phone number and any reference or tracking information associated with the Medicaid program you paid the fee to:

Provider's Attestation, Signature, and Date

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity, duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Provider's signature (Signature and date stamps, or the signature of anyone other than the provider or a person legally authorized to sign on behalf of a legal entity, are not acceptable.)

Printed legal name of provider: _____ Date: _____

This form is also available online at www.mass.gov/masshealth (go to Information for MassHealth Providers/MassHealth Provider Enrollment and Credentialing/Enrollment, then go to the Application Fee section).