

**CERTIFICATION FORM
HOSPICE PROVIDER NURSING HOME LOG**

Hospice Name and Address (include County):

Prepared by: _____

Contact Phone: _____ **Contact e-mail:** _____

Medicaid Provider Number: _____ **Password:** _____

Reporting Period: From: _____ To: _____

Certification by Officer or Administrator of Hospice

I Hereby Certify That I Have Examined The Accompanying Logs Prepared By _____ For The Reporting Period Beginning _____ 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 Hospice In Accordance With Applicable Instruction, Except As Noted:

I Certify That I Am Familiar With The Laws And Regulation Regarding The Provisions Of Health Care Services Under The Florida Medicaid Program, Including The Laws And Regulation Relating To The Claims For Medicaid Reimbursements And Payments, And That The Services Identified In This Report Were Provide In Compliance With Such Laws And Regulations.

Signature of Officer or Administrator

Title

Date

Scan and email completed form to:
Hospice_Nhlogs@ahca.myflorida.com

