



ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
Public Health Department – Administrative Services
Finance-Contracts and Grant Claiming

SB 12 PHYSICIAN CERTIFICATION FOR REIMBURSEMENT OF UNCOMPENSATED EMERGENCY
MEDICAL SERVICES
CALENDAR YEAR 2019-2020

This certification is submitted by the undersigned medical entity for reimbursement under the SB 12 Program for uncompensated emergency medical services provided in a licensed general acute care hospital in Alameda County.

The undersigned:

1. Acknowledges possession of a copy of the “SB 12 Physician Reimbursement Guidelines” and agrees to comply with the terms and conditions governing the payment of claims.
2. Certifies that he/she/entity has complied fully with the reimbursement claiming conditions as outlined in the SB 12 Physician Reimbursement Guidelines.
3. Certifies that all other physician billing requirements, duties, and obligations, including but not limited to the preparation, maintenance and retention of service and finance records and their availability for audit, have been and will be observed.
4. Expressly acknowledges and understands that this Certification is to be filed yearly and is subject to those conditions defined in the Reimbursement Guidelines including, among others, availability of monies in the SB 12 Fund, and audit adjustments.
5. Certifies, under penalty of perjury, that the claims submitted for SB 12 reimbursement are true, accurate, and complete to the best of his/her/entity’s knowledge.
6. *[Applies to Electronic Data Interchange (EDI) only]* Acknowledges possession of a copy of the “EDI Trading Partner Guidelines” and the “EDI Companion Guide” and agrees to comply with the terms governing the exchange of electronic data contained therein.

Printed Name & Signature of Individual Physician, a Partner, or an Officer of the Corporation & **Date**

Full legal name of entity & address (type or print)

DBA (if applicable and different from above) to be used for SB 12 billing & **remittance address**

Type of Entity: Individual Sole Proprietor Partnership Medical Corporation

License Number _____ Tax ID Number (TIN) _____ SSN EIN

Billing Contact Name & Billing Company Name

Billing Contact E-mail Address

Billing Contact Phone Number

Billing Contact FAX Number

Hospital/Group/Affiliation

Certification Period: January 1, 2019– December 31, 2020