

Row #	Revenues from Third Party	Acct. Code	Revenue	Line Item	Grand Total
1	Revenues Federal Sources:	xxxxxxxxxx			\$ -
2	Direct Mental Health Federal Grants			\$ -	
3	Other			\$ -	
4				\$ -	
5	Revenues from Insurance:	xxxxxxxxxx			\$ -
6	Medicare			\$ -	
7	Insurance Companies			\$ -	
8				\$ -	
9	Other Payments (Detail in notes)			\$ -	
10				\$ -	
11	Revenues from Clients:	xxxxxxxxxx			\$ -
12	Client Payments			\$ -	
13	Other Client Payments			\$ -	
14				\$ -	
15	Revenues from Other (detail in notes):	xxxxxxxxxx			\$ -
16				\$ -	
17				\$ -	
18				\$ -	
19				\$ -	
20				\$ -	
	Total			\$ -	\$ -

Provider Ac

THIRD PARTY CERTIFICATION

I, _____ certify that during the time period of _____
 (Print Name) (Time Frame)

the _____ s sub contractors pursued all third party revenue prior to utilization of Medicaid funding.
 (Name of Provider)

Contractor further certifies that expenditures related to the reported third party revenue are not included in the Medicaid or Non-Medicaid report.

 Signature

REVENUE & EXPENDITURE REPORT

Reporting Agency: _____

- January – March 20____
- April – June 20____
- July – September 20____
- October – December 20____

I have reviewed this report and certify that to the best of my knowledge it is both complete and accurate.

Signed by: _____

Date: _____

By signing this form you assure that no payments were made directly or indirectly to physicians or other persons as inducements to limit services to recipients.

By signing this form you assure that the attached reports are your best estimate due to county or provider books not being officially closed.

If your Agency was audited during this report period, please attach a copy of your corrective action plan(s).

Provider Admin % (total Admin divided by total expense)

