This report is required by law (42 USC 1395g) and 42CFR 413.20 and 413.24.
Failure to report can result in all payments made during the reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0102
Expires: 09/30/2020

ORGAN PROCUREMENT ORGANIZATION HISTOCOMPATIBILITY LABORATORY GENERAL DATA AND CERTIFICATION STATEMENT	Provider CCN: _____	PERIOD: FROM:_____ TO:_____	WORKSHEET S

Contractor Use Only:

[ ] Audited [ ] Desk Reviewed Date Received _____ Contractor No. _____ [ ] Initial [ ] Final [ ] Re-opened

PART I - GENERAL

Check applicable box [ ] Electronic filed cost report [ ] Manually submitted cost report Date: Time:

1	Name: Provider CCN:		1
1	Street: P.O. Box:		1
1	City: State: Zip Code:		1
2	Name: Provider CCN:		2
2	Street: P.O. Box:		2
2	City: State: Zip Code:		2
3	Reporting Period: From To		3

		Type of Control (see instructions)	Type of Provider (see instructions)	Participation Date	
	1	2	3	4	
4					4

PART II-CERTIFICATION BY OFFICER OR ADMINISTRATOR OF FACILITY

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FUTHERMORE, IF SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWIS ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATION ACTION, FINES AND/OR IMPRISONMENT MAY RESULT

CERTIFICATION BY OFFICER, ADMINISTRATOR OR DIRECTOR OF ORGANIZATION/LABORATORY

I HEREBY CERTIFY that I have read the above cerification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____(Provider name(s) and CCN(s) for the cost reporting period beginning _____ and ending_____, and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the OPO/LAB in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer, Administrator or Director

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII		
		Organ Acquisition	Tissue Typing	
		1	2	
1	OPO/LAB			1

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB Control Number for this information collection is 0938-0102. The time required to complete this information collection is estimated to average 45 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form please write to: Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

FORM CMS-216-94 (06-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 3302, 3302.1 and 3302.2)