DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

May 2014 Enrollment and Payment Data Template

Submission Certification Form

I certify in my capacity as a financial authority contact (i.e., CEO or CFO or authorized delegate) of [Organization Name (Issuer or SBM)] to only one of the following selections per HIOS ID as indicated below that:

1) I have reviewed the information on the Enrollment and Payment Data Template(s) submitted to the Centers for Medicare & Medicaid Services (CMS). I further certify that to the best of my knowledge, information, and belief, the information provided is accurate. The information provided as of the submission date is a good faith estimate. If this submission includes a restatement for any month's data that was submitted previously, I understand the latest restatement is the official statement to serve as the basis for payments during that particular month. I understand the information included in this submission will be the basis for the calculation of the amount to be paid to, or collected from, [Organization Name (Issuer or SBM)], if any, in the month of May during this interim payment process. This amount will be reconciled by the Federal government once the regular payment process is fully implemented. This certification applies to the May submission, including any restatements provided in this submission, for the following HIOS Issuer IDs:

[List applicable HIOS IDs here or "N/A." Do not designate the selection down to the QHP level.]

2) This certification includes non-submission of Enrollment and Payment Data Template(s) for the HIOS Issuer IDs listed below because these issuers had zero effectuated enrollments as of April 15th, 2014. I understand that these IDs will be excluded from any payment calculation in the month of May.

[List applicable HIOS IDs here or "N/A." Do not designate the selection down to the QHP level.]

3) This certification includes non-submission of Enrollment and Payment Data Templates(s) for the HIOS Issuer IDs listed below because we are a stand-alone dental plan that does not expect to receive any APTC payments for the month of May. I understand that these IDs will be excluded from any payment calculation in the month of May.

[List applicable stand-alone dental HIOS IDs here or "N/A." Do not designate the selection down to the QHP level.]

Name of the Person Completing this form (Print or Type):

_____

Title: _____

Organization: _____

Telephone: _____

Fax Number: _____

Email Address: _____

Signature: _____ Date: _____