

**Mississippi Hospital QIPP Certification Form**

**CERTIFICATION STATEMENT OF**

|  |
| --- |
|  |

**Hospital Name**

|  |
| --- |
|  |

**Medicaid Provider Number**

TO THE

STATE OF MISSISSIPPI DIVISION OF MEDICAID

TO THE RECEIPT OF THE HOSPITAL PPHR and PPC REPORTS

FOR THE PERIOD:

|  |
| --- |
| June 30, 2021 |

**(Report for the Quarter Ended)**

|  |  |
| --- | --- |
| Name of Person Attesting: |  |

|  |  |
| --- | --- |
| Title: |  |

|  |  |
| --- | --- |
| Phone Number: |  |

***I hereby attest that the PPHR report for the hospital named above for the period indicated has been received.***

|  |  |
| --- | --- |
| Date of Attestation: |  |

***I hereby attest that the PPC report for the hospital named above for the period indicated has been received (Not applicable to Behavioral Health hospitals).***

|  |  |
| --- | --- |
| Date of Attestation: |  |

|  |
| --- |
|  |

Signature – Hospital CEO, CFO or Authorized Signatory

|  |
| --- |
|  |

 Title