

**Mississippi Hospital QIPP Certification Form**

**CERTIFICATION STATEMENT OF**

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**Hospital Name**

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**Medicaid Provider Number**

TO THE

STATE OF MISSISSIPPI DIVISION OF MEDICAID

TO THE RECEIPT OF THE HOSPITAL PPHR and PPC REPORTS

FOR THE PERIOD:

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| --- |
| December 31, 2021 |

**(Report for the Quarter Ended)**

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| 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.***

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| --- | --- |
| 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: |  |

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Signature – Hospital CEO, CFO or Authorized Signatory

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|  |

Title