**Provider’s Data Exception Attestation**

I, the Attester named below, hereby certify to **Central Florida Cares Health System, Inc.** that data submitted to cfchsdata.org represents, to the best of my knowledge, complete and reasonable billing of services provided to SAMH eligible clients.  Year-to-date Data submitted may include correction(s) to prior month(s) submitted data.  All data submitted to date is supported by details in our files, books and records.  Data submitted to cfchsdata.org was reviewed for validity and accuracy.  Any data remaining on CFCHS “Exception Reports” for our agency are accurate and should not be removed from units of service used to calculate payments due.  A written explanation as to why CFCHS should accept data that remains on our “Exception Reports” as correct was provided to our CFCHS Contract Manager.

Signature of Attester: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Attester: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title or Profession of Attester: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_