I,___________________________________, am an authorized representative of ______________________ (CPC Practice). To the best of my knowledge and belief, under penalty of perjury, I attest to all of the following terms, as established by the Ohio Administrative Codes Sections 5160-19-01 and 5160-19-02:

- The CPC Practice commits to meeting activity requirements as specified by Ohio Department of Medicaid and set forth in Ohio Administrative Code Section 5160-19-01.
- The CPC Practice commits to participating in learning activities as directed by the Ohio Department of Medicaid.
- The CPC practice commits to sharing data requested by the Ohio Department of Medicaid and Ohio Medicaid Managed Care Plans, in accordance with the requirements of the Health Insurance Portability and Accountability Act.

____
CPC Practice Name

____
Address

____
Medicaid Billing ID

____
Signature

____
Printed Name

____
Date