

Encounter Data Certification and Validation Report Form*

This form must be submitted concurrently with each encounter data or pharmacy transaction submission, if by facsimile to phone number 503-945-9908.

Plan Name: _____ Plan DMAP Number: _____

Submission Date: _____ Type of submission: _____
Month/Day/Year Encounter/Pharmacy

Total Claim Count**		Total Billed Amount **	\$
---------------------	--	------------------------	----

I, the undersigned, hereby attest that I have authority to certify the data and information on behalf of Contractor, as authorized by Signature Authorization Form; and I, the undersigned, hereby certify based on best knowledge, information and belief that the data and information submitted to OHA are accurate, complete and truthful; and that the data and information contained in this Encounter Data Certification and Validation Report Form, are accurate, complete and truthful.

Print Name of CEO/CFO or delegate

Print Title of CEO/CFO or delegate

Signature
(must match the signature authorization form)

Date

Contractor may, at Contractor’s discretion, submit more detailed submission totals than the minimum necessary required above, to do so contact your designated Encounter Data Liaison.

An Encounter Data Certification and Validation Report Form submitted to OHA that omits required information will not meet the requirements of Certified and Validated Data and will not be accepted by OHA.

* Total Claim Count and Total Amount Billed includes all Claims sent to OHA for processing (new, adjustments or deletes)