DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0	November 15, 2005	Initial version Uniform Managed Care Manual Chapter 5.3.5.3 Delivery Supplemental Payment (DSP) File Submission Instructions
Revision	1.1	September 1, 2006	Chapter 5.3.5.3 is modified to provide clarification resulting from the implementation of the Joint Medicaid/CHIP HMO Contract.
Revision	1.2	March 30, 2007	Chapter 5.3.5.3 is modified to include the CHIP Perinatal Program and to add an Appeals Process.
Revision	1.3	January 2, 2009	Chapter 5.3.5.3 is modified to clarify the percentage breakdown for the CHIP Perinatal Program, to clarify data elements, and to include instructions for completing the Data Certification Form that accompanies the DSP file.
Revision	1.4	May 5, 2011	Chapter 5.3.5.3 is modified to add Qualified Alien risk groups to the STAR eligibility table. DSPs were available for these groups for dates of service on or after May 1, 2010.
Revision	2.0	December 6, 2012	"Applicability" is modified to remove CHIP Perinatal. "Eligible STAR Risk Groups" is modified to add Risk Code 30. "DSP Procedures: Appeal Process" is modified to clarify the process.
Revision	2.1	October 1, 2013	"Eligible STAR Risk Groups" is modified to include the Risk group changes for deliveries on or after September 1, 2013. Revision 2.1 applies to contracts issued as a result of HHSC RFP numbers 529-08-0001 and 529-12-0002.
Revision	2.2	October 1, 2015	"General Instructions" is modified to update the CHIP perinatal designations from "above 185% to 200% FPL" to "above the Medicaid eligibility threshold" and from "the 0% to 185% FPL" to "at or below the Medicaid eligibility threshold." "Data Verification" is modified to update the CHIP perinatal risk group Code 06 from "above 185% to 200% FPL" to "above the Medicaid eligibility threshold." "DSP Procedures: Appeal Process" is modified to update edit #E118 from "in the 0% to 185% FPL" to "at or below the Medicaid eligibility threshold."

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	2.3	June 1, 2016	"Applicability of Chapter 5.3.5.3" is modified to add a description of DSP payments. "Data Submission – Data Elements" is modified to update data element size for Member Risk Code and clarify file layout instructions. Updated information on file rejection causes. "Data Submission – File Layouts" is modified to update information on file rejection causes. "Data Submission – Protocol and Frequency for Submission by the Plans" is modified to include Health Plan Management information and to provide file naming conventions for Appeal files. "Data Submission – File Naming Convention for the Response File" is modified to remove "E (Edit102)." "Data Submission – File Naming Convention for the Appeal File" is added. "Data Verification" is modified to delete STAR Risk Groups (effective through 8/31/2013 Delivery Date), update Risk Codes for Eligible STAR Risk Groups, Eligible CHIP and CHIP Perinatal Risk Groups (effective through 8/31/2015) and add a section to indicate current Eligible CHIP and CHIP Perinatal Risk Groups; to delete Service Date Verification; to update Procedure/Diagnosis Code Check Edit; and to delete Payment Edit Checks (FFS Claims). "DSP Procedures: Appeal Process" is modified to update appeal process including updating the Edit Table for appeal codes. "Data Certification Form" is modified to clarify that files received without a signed Data Certification form will be rejected.
Revision	2.4	July 1, 2016	"Data Elements" Items V, W, and X are modified to clarify admit, delivery and discharge date requirements on DSP claims. "Data Verification" is modified to delete requirement that admit, delivery and discharge date data elements must be populated on all claims. "Data Submission – Data Elements" Item E112 is deleted.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	2.5	March 1, 2017	"Data Submission – Protocol and Frequency for Submission by the Plans" is modified to update the HHSC email contact. "Data Submission – File Naming Convention for the Appeal File" is modified to update the HHSC email contact.
Revision	2.6	February 1, 2018	"Data Submission – File Layout" is modified to update information regarding filters and external links to the claim submission templates. "Data Submission – File Naming Convention for the Response File" and "File Naming Convention for the Appeal File" are modified to provide further detail regarding file submissions. "Data Verification - Member Verification" is modified to remove Member Last Name as one of the elements that would be used to verify client identity. "Data Verification - Risk Group Classification" is modified to include Adoption Assistance & Permanency Care Assistance (AAPCA) under Eligible STAR risk groups. "Data Verification - Procedure/Diagnosis/DRG Code Check Edit" is modified to require at least two diagnosis codes and one procedure code\revenue code to support the validity of the DSP claims with date of delivery on/after Feb 1, 2018 "DSP Procedures: Appeal Process" is modified to include information on the file formats for the MCO submissions and to clarify where HHSC would be posting the approved files. "DSP Procedures: Appeal Process" is modified to update Edit Description and Appeal Process for Edit Numbers E104, E110, E111 and E116.

Revision	2.7	March 21, 2022	"**Data Submission - File Layout"** is updated to clarify that rejected "Stillbirth" deliveries less than 20 gestational weeks are not eligible for appeals. Additionally, the requirement of a letter "X" at the bottom of column "A" of each DSP data file submitted was removed. A reference to the updated "**HHSC_DSP_ ICD-10_Code_list EFFECTIVE 12-01-2021.xlsx**" was added. "**Data Submission - Protocol and Frequency for Submission by the Plans**", is modified to update HHSC's contact information for "Delivery Supplemental Payments" communication. Additionally, a note regarding "Appeals email notification" was added to provide more context regarding the notification requirement. "**Data Submission - File Naming Convention for the Appeal File**" is modified to update examples with November & December 2021 dates and to update HHSC contact information. "**Data Verification**" section "**5. Procedure/Revenue/Diagnosis/DRG Code Check Edit**" is modified to remove the paragraph regarding "Claims with Date of Delivery before February 1st, 2018". "**DSP Procedures: Appeal Process**", is modified to clarify the Edit Description of Edit Code E111 by adding that "Stillbirth" deliveries are payable by HHSC **only when** a "Diagnosis code" "Z3A.XX" of 20 gestational weeks or higher (i.e. Z3A.20, Z3A.21, Z3A.22…) is provided by the MCO along with any other required data in the "C" File submitted for payment consideration.

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

Applicability of Chapter 5.3.5.3

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR and CHIP Programs. In this chapter, references to "CHIP" or the "CHIP Managed Care Program(s)" apply to the CHIP Program. References to "Medicaid" or the "Medicaid Managed Care Program(s)" apply to the STAR Program. The term "MCO" includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, and any other entities licensed or approved by the Texas Department of Insurance. The requirements in this chapter apply to all programs, except where noted.

A one-time Delivery Supplemental Payment (DSP) payment is made to the MCOs in the amount identified in the HHSC Managed Care Contract document regardless of whether there is a single birth or there are multiple births at time of delivery. A delivery is the birth of a live born infant, regardless of the duration of the pregnancy, or a stillborn (fetal death) infant of ***twenty (20) weeks or more of gestation***. A delivery does not include a spontaneous or induced abortion, regardless of the duration of the pregnancy.

The MCO will not be entitled to DSPs for deliveries that are not reported to HHSC within 300 days after the date of delivery, or within thirty (30) days from the date of discharge from the Hospital for the stay related to the delivery, whichever is later.

General Instructions

Submission for DSPs will be submitted for Members in the STAR and CHIP Programs. The two Programs are submitted separately. Template to be used for STAR claim submission is "UMCM 5.3.5.2 - DSP Medicaid Format" and the template for CHIP claims is "UMCM 5.3.5.1 - DSP CHIP Format".

The CHIP submission will include deliveries for Perinate Members above the Medicaid eligibility threshold only. Deliveries for Perinate Members at or below the Medicaid eligibility threshold are not eligible for DSP. For these Perinate Members, the MCOs should direct providers to submit claims for facility charges to HHSC's Claims Administrator, for consideration for payment under Emergency Medicaid.

CHIP deliveries and CHIP Perinate deliveries for Perinate Members above the Medicaid eligibility threshold may be submitted in the same file.

Data Submission:

- **Data Elements**

Templates for STAR and CHIP claim submission include the following data elements:

No	Data Element	Description	Type	Size
A	Health Plan Code	Contract ID	Text	2
B	ICN Number/Claim Number	ICN or claim number assigned to claim by the MCO	Text	20
C	Member Medicaid/CHIP ID	Member Medicaid/CHIP ID	Text	9
D	Member Last Name	Mother's last name as appears on eligibility file	Text	25
E	Member First Name	Mother's first name as appears on eligibility file	Text	25
F	Member Date of Birth	Mother's date of birth Format = MM/DD/ YYYY	Date	10
G	Member Risk Code	Mother's risk code	Numeric	3
H	Enrollment Effective Date with Plan	Member's effective enrollment start date with MCO. If more than one, last enrollment date prior to service delivered. Format = MM/DD/YYYY	Date	10
I	Disenrollment Date from Plan (if any)	Date of member disenrollment from plan, if pertinent Format = MM/DD/YYYY	Date	10
J	Diagnosis Codes 1 (if UB-92 is used)	up to eight alpha-numeric character Group 1 or Group 2 diagnosis code	Text	8
K	Diagnosis Codes 2 (if UB-92 is used)	up to eight alpha-numeric character Group 1 or Group 2 diagnosis code	Text	8
L	Diagnosis Codes 3 (if UB-92 is used)	up to eight alpha-numeric character Group 1 or Group 2 diagnosis code	Text	8
M	Diagnosis Code 4 (if UB-92 is used)	up to eight alpha-numeric character Group 1 or Group 2 diagnosis code	Text	8
N	Diagnosis Code 5 (if UB-92 is used)	up to eight alpha-numeric character Group 1 or Group 2 diagnosis code	Text	8
O	Diagnosis Code 6 (if UB-92 is used)	up to eight alpha-numeric character Group 1 or Group 2 diagnosis code	Text	8

P	Diagnosis Code 7 (if UB-92 is used)	up to eight alpha-numeric character Group 1 or Group 2 diagnosis code	Text	8
Q	Diagnosis Code 8 (if UB-92 is used)	up to eight alpha-numeric character Group 1 or Group 2 diagnosis code	Text	8
R	Diagnosis Code 9 (if UB-92 is used)	up to eight alpha-numeric character Group 1 or Group 2 diagnosis code	Text	8
S	Diagnosis Code 10 (if UB-92 is used)	Up to eight alpha-numeric character Group 1 or Group 2 diagnosis code	Text	8
T	Procedure Code\Revenue Code	Procedure code for Professional claim or Revenue code for Inpatient Facility claim	Text	5
U	DRG Code	DRG Code	Text	5
V	Admission Date to Hospital (if UB 92 is used)	Date of admission (in-patient claims) Format = MM/DD/YYYY	Date	10
W	Discharge Date from Hospital (if UB 92 is used)	Date of discharge (in-patient claims) Format = MM/DD/YYYY	Date	10
X	Delivery Date	Delivery date related to this service Format = MM/DD/YYYY	Date	10
Y	Institution/Billing Provider Last Name	Name of Institution or Last name of the Billing Provider	Text	25
Z	Billing Provider First Name	First name of the Billing Provider	Text	25
AA	Billing Provider Medicaid/CHIP Number (from State file)	Billing provider's Medicaid or CHIP number	Text	9
AB	Claim Receipt Date from Provider	Date that claim was received from the provider by the health plan Format = MM/DD/YYYY	Date	10
AC	Claim Paid Date (if FFS claim)	Date that claim was paid by the health plan Format = MM/DD/YYYY	Date	10
AD	Check Number (if FFS claim)	Up to 15 characters	Text	15
AE	Paid Amount (if FFS claim)	Amount that is paid to the provider in dollars Format = 999999.99	Numeric	9
AF	Capitated or FFS Service	If service is capitated or FFS (C or F)	Text	1
AG	Override Field	Field to be used with resubmissions. Will be provided by HHSC, when necessary.	Text	12

- **File Layout**

MCOs must complete the STAR and CHIP data using the Microsoft Excel templates provided by HHSC (UMCM 5.3.5.1 & 5.3.5.2). Data integrity is critical to the automated compilation of the data. Do not alter the headers, sheet names, existing cell locations, existing tab locations, or formatting of the data in the file and sheets. Do not add or delete any columns or rows 8a add not have any filters on. Templates should not be submitted with any external links and data in the sheets should be values only (no formulas).

Submit the file to HHSC in Excel. See attached report layout. Upload the DSP reports to TXMedCentral.

STAR DSP reports will go to the MCO's DELIV folder with a specific file name given to each MCO.

CHIP DSP reports will go to the MCO's CHIP folder with a specific file name given to each Health Plan.

Complete and submit a signed Data Certification Form with each submission file. Please see "Data Certification Instructions" section for more information.

File submissions using incorrect or changed templates, incorrect naming conventions or incomplete/missing data certification forms will be rejected. Any claims on these impacted files will need to be resubmitted for processing the following month. Note: In the event that a claim on the impacted file is denied the following month, due to Edit 116, such a claim is not eligible for appeal. Additionally, if a claim is rejected due to a stillbirth delivery that was less than 20 gestational weeks, such a claim is not eligible for DSP payment and cannot be appealed. Please refer to the most recent DSP Codes list document "HHSC_DSP_ICD-10_Code_list EFFECTIVE 12-01-2021.xlsx", available for MCOs to download from the TXMedCentral MCOLAYUT folder updated with valid outcome codes for stillbirth claims with ≥20 gestational weeks at time of delivery.

- **Protocol and Frequency for Submission by the Plans**

The MCOs will submit the DSP reports for STAR, CHIP and CHIP Perinatal Program on the first business day of each month.

HHSC will pay the MCOs within twenty (20) business days from the given deadline. HHSC will not process reports that are filed past the given deadline and the MCO will need to include claims with its next monthly claim file submission.

HHSC will validate the submitted reports utilizing a set of edits and audits. Those records on the submitted file that fail to pass these edits and audits will be rejected back to the MCOs on a response file within two weeks after receipt of the submitted report. If the MCO has questions on its response file, the MCO may contact HHSC by e-mail at DSPTeam@hhs.texas.gov and copy their Health Plan Management (HPM) team. If the

MCO is able to correct the information on the rejected records, they can be submitted in the next cycle. On a regular basis, HHSC will audit medical records to validate the submitted data.

- **Media for Submission by the Plans**

STAR MCOs will upload reports in Excel format to the TXMedCentral in their individual DELIV libraries.

CHIP and CHIP Perinatal MCOs will upload reports in Excel format to the TXMedCentral in their individual CHIP libraries.

- **File Naming Convention for the Submitted File**

The file name should follow the naming convention specified:

1	2	3	4	5	6	7

1 = C (delivery report)
2–3 = plan code
4–5 = month
6–7 = year

- **File Naming Convention for the Response File**

The file name should follow the naming convention specified:

1	2	3	4	5	6	7

1 = A (Accepted), R (Rejected), and O (Accepted Appeal)
2–3 = plan code
4–5 = month
6–7 = year

- **File Naming Convention for the Appeal File**

The Appeal form should be in Excel file format while any documentation can be in Excel/Word/PDF file format. File name(s) should follow the naming convention specified:

1	2	3	4	5	6	7	8	9	10	11	12	13

1-6 = “Appeal”
7-9 = plan code
10-11 = month
12-13 = year
(Example: AppealAET1121; AppealMOL1221)

Note: Please notify HHSC of the appeal file name, and the folder name by e-mail at DSPTeam@hhs.texas.gov and copy your HPM team. MCO’s failure to send an email notification regarding submitted appeals may result in those appeals not being processed that month.

Data Verification:

1. **Missing Data Elements**
   HHSC will reject service lines with missing or incomplete required data elements that are needed to verify and validate service delivery.

2. **Member Verification**
   HHSC will validate the submitted delivery reports against the member eligibility file. This file will be compared against the delivery reports submitted by the MCOs in order to verify client identity. Data elements utilized for member verification will include member date of birth, and member Medicaid/CHIP/CHIP Perinatal ID.

3. **Risk Group Classification**
   HHSC checks the recipients’ risk group classification against HHSC eligibility data. If a recipient is classified in a risk group eligible for payment, the MCO will receive a supplemental payment for that recipient.

   Eligible STAR Risk Groups:

Risk Code	Description
003	TANF Adult
005	Pregnant Women
020	Pregnant Women – Qualified Alien
064	Age 6-14 Child
065	Age 6-14 Child – Qualified Alien
066	Age 15-18 Child
067	Age 15-18 Child – Qualified Alien
068	Age 19-20 Child

069	Age 19-20 Child – Qualified Alien
070	Adoption Assistance & Permanency Care Assistance (AAPCA)

Eligible CHIP and CHIP Perinatal Risk Groups:

Risk Code	Description
303	Age Group 6-14
304	Age Group 15-18
310	Perinatal Mother > 198% and <= 202% FPL

4. Plan Affiliation for Medicaid, CHIP, and CHIP Perinatal

HHSC will validate plan affiliation for the enrolled Member at the date of service. The plan code be an MCO plan code for CHIP, CHIP Perinatal, or STAR. MCOs must submit a separate DSP report for each plan code.

5. Procedure/Revenue/Diagnosis/DRG Code Check Edit

Claims with date of delivery on/after February 1st, 2018, whether a Professional or Inpatient Facility claim, must have at least one Group 1 diagnosis code and at least one Group 2 diagnosis code. Group 1 diagnosis codes indicate Main Circumstance or Complication of the Delivery (e.g. O80) while Group 2 diagnosis codes identify the Outcome of Delivery (e.g. Z37.0). Any of the ten fields (data elements J through S) of the templates can be used for a Group 1 or a Group 2 diagnosis code. The approved DSP eligible Group 1 and Group 2 Diagnosis code list for deliveries on or after February 1st, 2018 ("HHSC_DSP_ ICD-10_Code_list EFFECTIVE 12-01-2021.xlsx") is available for MCOs to download from the TXMedCentral MCOLAYUT folder.

In addition to diagnosis codes, all claims with date of delivery on/after February 1st, 2018 must contain a valid Procedure Code for Professional services claim or a Revenue Code for Inpatient Facility claim (instead of a Procedure Code). The Procedure Code for a Professional service claim or the Revenue Code for an Inpatient Facility claim need to be entered into data element T ("Procedure Code\Revenue Code") of the templates. HHSC DSP eligible Procedure and Revenue codes are also provided in the file "HHSC_DSP_ ICD-10_Code_list EFFECTIVE 12-01-2021.xlsx" posted in TXMedCentral MCOLAYUT folder.

All claims from a plan code, irrespective of date of delivery associated with the claim, must be submitted together in the same "C" file for monthly processing.

6. Duplicate Checking

A duplicate checking system will verify that all claims/encounters are unique within and

across MCOs. This system will involve the comparison of the Member Medicaid /CHIP/CHIP Perinatal ID and delivery date for all incoming records on the same cycle and against history data.

7. **Gender Check**
   HHSC will check that the gender of the client that delivers is female (utilizing the gender of the member from the eligibility file)

DSP Procedures: Appeal Process

HHSC processes and posts files that identify those claims that are approved for payment (“A” DSP files) and those that are rejected (“R”DSP files) to TXMedCentral DELIV and CHIP folders accordingly.

Of those that were rejected, claims that an MCO considers payable should be appealed or resubmitted based on the specific circumstances.

For Edit 102 rejections, it is best to resubmit the claim along with a plan's regular submission the following month. This gives eligibility data time to catch up in the event of recent eligibility changes.

For other edits that may be the result of an incorrect data entry, corrections should also be submitted the following month along with the plan's regular submission.

For other types of edits, and for resubmissions that are rejected a second time, the Plan may choose to appeal the claim. It is very important that a single claim not be resubmitted and appealed at the same time.

When appealing a claim, an MCO must submit the DSP claim(s) on an Excel DSP Appeal Form and attach necessary documentation in an Excel\Word\PDF file format to TXMedCentral under the MCO's CHIP or Medicaid (DELIV) folder. Documentation can be submitted as a separate file or embedded in a new sheet of the Excel appeal form. Notify HHSC of the file name(s) and location. See UMCM Chapter 5.3.5.5, DSP Appeal Form CHIP and Chapter 5.3.5.6, DSP Appeal Form Medicaid for Appeal templates.

MCOs submit appeal files within the 3rd week of the month to allow time for the review of their appeals and submitted documentation. Appeals that are approved are posted to the TXMedCentral as an O-file.

Edit codes for rejected claims, description of the codes and appeal process are further described below:

Edit Number	Edit Description	Appeal Process
E102	Claim is denied because the PCN (Medicaid/CHIP/CHIP Perinatal number) is not found in HHSC's managed care eligibility file in the month of the delivery	There are times when eligibility files are updated after the MCO submits a claim. In this case please resubmit in the following month's C File. If the MCO needs to appeal due to admission date and eligibility status, then MCO will need to submit claim documentation that includes hospital admission date, discharge date, delivery dates and valid codes.
E103	Claim is denied because the eligible (PCN) was enrolled in a different MCO during the month of delivery.	Only resubmission by correct MCO will result in payment. There are times when eligibility files are updated after MCO submits a claim. In this case please resubmit in the following month's C File. If MCO needs to appeal due to admission date and eligibility status, then MCO will need to submit claim documentation that includes hospital admission date, discharge date and delivery dates and valid codes.
E104	Claim is denied because the date of birth entered in the delivery submission file does not match the date of birth found for this recipient in HHSC's managed care eligibility file.	MCO's submission file may be incorrect or it may be a data entry error in the eligibility file. If MCO error, resubmit with corrected date of birth. If eligibility file error, no documentation is needed for the appeal. The date of birth must be correct on the C-file in order for payment to be made so do not appeal if MCO needs to edit the field.

E107	Claim is denied because the managed care eligibility file indicates that this recipient is male.	Claim cannot be paid by HHSC until gender is corrected in eligibility records. HHSC cannot make this change. Once corrected, resubmi
E108	Claim is denied (suspended) because the client is younger than 12 years of age or older than 45 years of age.	MCO needs to appeal and send proof of delivery including client ID, valid codes, admission date, discharge date and delivery date.
E109	Claim is denied (suspended) because the same client has had another delivery within 9 months of this delivery date.	MCO must always send proof of delivery that includes client ID, hospital admission date, discharge date and delivery date and valid codes, gestational age if available.
E110	Claim is denied because HHSC's records indicate that HHSC has already made a supplemental delivery payment for this delivery.	MCO must always send proof of delivery that includes client ID, hospital admission date discharge date, delivery date, valid codes and gestational age, if available.
E111	Claim is denied because it does not have all the required types of delivery codes (diagnosis\procedure \revenue) and\or codes are not valid codes that are approved by HHSC for a DSP and/or a stillbirth diagnosis code requirement of ≥ 20 gestational weeks was not met.	Resubmit with all required types of codes and/or corrected codes or submit delivery documentation with codes that fit the HHSC code requirements. See *Data Validation, Section 5 - Procedure/Revenue/Diagnosis/DRG Code Check Edit* for HHSC code requirements and approved codes list.
E113	Claim is denied because it is for a risk group that is not eligible for a supplemental payment. HHSC checks the recipients' risk group classification against HHSC eligibility data.	Claim cannot be paid by HHSC until risk group is corrected in the eligibility records. HHSC cannot make this change. Once corrected, resubmit.

E116	Claim is denied because the delivery date is more than 300 days prior to the submission date in accordance with Joint Medicaid/CHIP MCO Contract, Attachment A, Section 10.09, "Delivery Supplemental Payment for CHIP, CHIP Perinatal and STAR MCOs."	Claim cannot be paid by HHSC unless proof of less than or equal to 300 days between delivery date and submission date is submitted.
E118	Claim is denied because Perinate member is at or below the Medicaid eligibility threshold per the CHIP eligibility file.	Submit facility claim to HHSC's Claims Administrator if Perinate Member is at or below the Medicaid eligibility threshold at time of delivery. Otherwise, appeal with HHSC with no documentation needed.

When submitting an appeal to HHSC, the DSP Appeal Form is required. (See UMCM Chapter 5.3.5.5, DSP Appeal Form CHIP, and Chapter 5.3.5.6, DSP Appeal Form Medicaid.) Appeals submitted without a DSP Appeal Form will not be reviewed.

Data Certification Form

General Instructions:

The Data Certification Form must be submitted with the DSP Reports, and it must be signed by the CEO/Administrator, CFO, or a Delegated Representative who is a direct report to the CEO or CFO.

Certification of certain financial data is a Federal requirement. The Data Certification Form is generic in order to apply to different financial reports.

The Certification tab in the DSP Medicaid/CHIP Format submission templates has been included so that a PDF version of the Data Certification Form can be inserted into the tab. PDF version of the Data Certification Form must be legible. If there is not a signed Data Certification Form attached, the entire file will be rejected and not processed at all.

Instructions for Completing Specific Data Fields: Data

Field 1 – Enter the name of the MCO.
Data Field 2 – Enter the MCO's Plan Code.
Data Field 3 – Enter the file or document name
Data Field 4 – Enter the submission date to HHSC.

Data Field 5 – Enter the name and title of the person signing the Certification (CEO/Administrator, CFO, or a Delegated Representative who is a direct report to the CEO or CFO).
Data Field 6 – Enter the date the form is signed.
Data Field 7 – Sign the certification. An image of the signature may be placed on the signature field.