HEALTHCARE CERTIFICATION FORM

AGENCY NUMBER _____ ***AGENCY NAME*** _____ ***COVERAGE MONTH*** _____

I certify that all automated healthcare reconciliation reports have been reviewed. The reconciliations for all healthcare plans reported on the U107 have been deemed proper and correct with the exception of those listed below. Any required adjustments have been documented and the related Interagency Transaction Voucher (IAT) enclosed.

Provider Name	**Group Number**	**IAT Adjustment Amount**

Approved by _____ Date _____

Signature of Approving Officer