COMMUNITY FIRST
HEALTH PLANS

December 23, 2020

CHIP Copay Waiver Provider/Group Attestation Form

I,_____ *(Provider/Provider Designees)*, certify that the attached invoiced amounts represent office visit co-pays that my practice did NOT collect for dates of service from **March 13, 2020 through January 21, 2021 or through the PHE (Public Health Emergency)**, for CHIP members in accordance with direction from Texas Health and Human Services (HHSC).

The above and the attached are true and correct to the best of my knowledge and belief. I know that I may be subject to penalties if I provide false or untrue information. All original documents will be retained and preserved as required by law, and such documents will be submitted, or access to such documents permitted, as required by HHSC or any agency of the state or federal government, or their representative(s).

_____ _____

Signature *(Provider/Provider Designees)* Date

_____

Contact Email Address

_____

Provider/Group Name (Please print clearly)