

# Physician's Certificate of Responsibility

It is recognized by \_\_\_\_\_ (hereinafter referred to as the Billing Agent)  
(Trading Partner Name)

that certain advantages will accrue to it and the undersigned physician or supplier through an arrangement whereby the Billing Agent can submit claims on behalf of the undersigned physician or supplier to third party payers for services or supplies (hereinafter individually referred to as the Carrier). This agreement between the physician or supplier and the billing agent is to be used for the purpose of allowing the Carrier to process claims submitted on behalf of the physician or supplier by the Billing Agent. Therefore, the undersigned physician or supplier agrees to the following:

1. I hereby authorize the Billing Agent to submit claims on my behalf, and I hereby acknowledge that the Billing Agent has rendered such services on my behalf.
2. I agree that the Secretary of the United States Department of Health and Human Services, his designee or agent, or the Carrier has the right to audit and confirm any information submitted by me, and has access to my claims documentation records and all records, including medical records, in my office or any other place for that purpose. Any incorrect payments which are discovered as a result of such an audit will be adjusted according to the applicable provisions of the Social Security Act as amended, Federal Regulations, or Medicare guidelines.
3. I shall not knowingly submit claims which conflict with the Social Security Act as amended, Federal Regulations, or Medicare guidelines.
4. I agree to maintain, or arrange for the Billing Agent to maintain, all original source documents.. I will ensure that every electronic entry can be associated and identified with a source document. All original source documents and medical records will be retained pursuant to the applicable State Law.
5. I understand that the Carrier has the right not to accept claims covered by this agreement for any reason.
6. I understand that I am responsible for any claim submitted on my behalf by the Billing Agent and that I am liable for any subsequent adjustment of that payment.
7. I understand that the submission of any claims is a claim for payment and that anyone who misrepresents or falsifies any record or other information essential to that claim or that is required pursuant to this agreement may upon conviction, be subject to fine and imprisonment under Federal Law.

I have read and agreed to the above by signing below on this \_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_

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Physician – Supplier Name

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Address

City

State

Zip Code

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Signature

Title