Attachment B

Managed Care Reimbursement Program
Primary Care Rate Increase (PCRI) Report
Report Period: Calendar Year 2013

CERTIFICATION

Managed Care Plan Name: **Report Submission Date:**

_____ _____
mm/dd/yy

The undersigned hereby certifies that to the best of my informed knowledge and belief the statements made herein and the documents attached hereto are accurate, true and complete in all material aspects.

I understand that the New York State Department of Health is relying upon this certification as part of its review and approval process, and that should it be determined that this certification is materially false or incomplete or incorrect or includes incorrect, false or misleading information, appropriate enforcement action will be taken.

Signature: _____
Chief Executive Officer

Date: _____

Signature: _____
Chief Financial Officer

Date: _____

This certification should be signed by the Chief Executive Officer or Chief Financial Officer (or the person having charge of the financial records of the plan).