Parkland Community Health Plan
PO Box 569005
Dallas, TX 75356-9005
HEALTH*first* 1.888.672.2277
KIDS*first* / CHIP Perinate 1.888.814.2352

Optional Optional COVID-19 CHIP Provider Co-payment Attestation Form

I, _____, (Provider Name/Group Name) certify that the attached invoiced amounts represent office visit co-pays that my practice did not collect for dates of service on March 13, 2020 through July 31, 2020, for CHIP members in accordance with direction from Texas Health and Human Services.

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).

_____ _____

Provider or Authorized Name -PRINT Signature

Provider/Billing Group Tax ID: _____

Provider/Billing Group NPI: _____

Date: _____