



## CHILDBIRTH EDUCATION

A COPY OF THIS LETTER AND PROOF OF STAFF CERTIFICATION TO PROVIDE  
CHILDBIRTH EDUCATION MUST BE KEPT ON PREMISES.

### PROVIDER ATTESTATION LETTER

Name of Agency 'OR' Provider: \_\_\_\_\_

Provider Number: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Dear North Carolina Medicaid Program:

As the owner/operator/manager of a Childbirth Education entity, I certify that our agency is currently in compliance with the staff qualification requirements of DMA's Clinical Coverage Policy No.:1M-2, to employ childbirth educators who are certified by a nationally recognized organization or state-approved childbirth education program.

Furthermore, I attest that all future staff members who will provide childbirth education in my facility shall meet these same requirements.

I understand that it is my responsibility to verify and keep copies of all staff qualifications for the provision of childbirth education in my facility. These staff certification copies will be maintained on-site for inspection and auditing by the Division of Medical Assistance and the Division of Public Health.

Signature \_\_\_\_\_ Title \_\_\_\_\_

*This attestation must be signed by an individual who has legal authority to obligate the facility.*

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**SUBMIT THIS FORM TO:  
DMA PROVIDER SERVICES  
2501 MAIL SERVICES CENTER  
RALEIGH, NC 27699-2501  
PHONE: 919-855-4259  
FAX: 919-715-8548**