ELECTRONIC SIGNATURE VERIFICATION STATEMENT

Michigan Department of Health and Human Services

The DCH-3890 form must be submitted by the Medicaid provider as verification of electronic signature security.

By signing this form, providers attest that measures are in place to protect the security of this electronic signature.

This signature verification form will be in effect until such date that the signatory party changes.

Field Name	Instructions
Provider Name	The name of the Medicaid enrolled provider (for the School Based Services Program this is one of the 56 Intermediate School Districts, Michigan School for the Deaf or Detroit Public Schools).
Program/Application	The name of the program or application (i.e., FQHC, PCG financial certification, School Based Services (MAER).
NPI (National Provider Identifier)	The unique identification number for covered health care providers mandated by the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard.
User ID	User identification for the MILogin portal or software user identification.
Local School District Name	Only applicable to the School Based Services Program. The name of the Michigan local school district.
Individual Printed Name	The printed name of the individual that will be submitting the electronic signature verifying the validity of cost submitted to the State of Michigan.
Individual Signature	The signature of the individual that will be submitting the electronic signature verifying the validity of cost submitted to the State of Michigan.
Date	Date of form completion and signature.

Pursuant to 42 CFR § 433.51, this Electronic Signature Verification Statement is intended to document a physical copy of my signature as part of the documentation required for the submission of visits and financial data.

I understand that this electronic signature is created with a unique combination of my computer login name and secure password. This unique combination is to ensure that all documentation is completed under this combination is done by me.

By signing this statement, I confirm that I will keep my password secure and that I will not inappropriately disclose this information to others. I also confirm that all documentation entered under my login name and password is true and correct. This form will remain in effect until the individual named on the form changes.

Provider Name	Program/Application	NPI

User ID	Local School District Name

Individual Printed Name

Individual Signature	Date

Form Submission

The completed original DCH-3890 must be mailed:

Michigan Department of Health and Human Services
Bureau of Medicaid Operations
Hospital and Clinic Reimbursement Division
Rate Review Section
PO Box 30479
Lansing, MI 48909

Questions should be directed to MDHHS Medical Services Administration, Rate Review Section, via telephone at **517-335-5330.**

Authority: Public Act 305 § 450.832 and 42 CFR § 433.51 **Completion:** Mandatory for payment.	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.