

**Mississippi Medicaid CLIA Certification Information**  
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**General Instructions:** Please complete this form. If more than one CLIA number is used, each number must be listed. Forms that are illegible/incomplete will be returned.

Please indicate whether you WILL or WILL NOT Bill for lab services. If you WILL NOT Bill for lab services, please sign on the first signature below, do not complete any other part of this form and return with your provider application.  
 If you WILL Bill for lab services, please complete this form and return with your provider application.

I WILL Bill for Lab Services                       I WILL NOT Bill for Lab Services

**Provider Name** **Provider Contact**

**Provider Number** **Provider Telephone Number**

**Provider's Address (City, State and Zip Code)**

**CLIA Certification Number**

**Address of Lab**

**Signature - (Signature Stamps are NOT Acceptable)** **Date**

If the CLIA number is not issued to the person/entity indicated above, please provide below a signature from the provider to whom the CLIA number is issued and who authorizes your use of the laboratory location and corresponding CLIA number.

**Signature**

I have authorized the above provider to use the laboratory facilities associated with my CLIA number and therefore, to bill claims to Medicaid using my CLIA number.  
 Please legibly print the name of the person who has legal authority for the CLIA number/location in the space below.

**Name**

**Address**

**Phone Number**

**Signature – Signature Stamps are NOT Acceptable** **Date**

**A COPY OF THE CLIA CERTIFICATE MUST BE ATTACHED – If the CLIA certificate is not available, attach a copy of the documentation which substantiates the CLIA number.**