



**NC Innovations Waiver
Monthly Deductible Verification Attestation**

Purpose: This form is completed by an authorized MCO representative to verify a participant's monthly deductible status for payroll processing purposes.

Participant Information

Participant Name	
Medicaid ID	
Deductible Month & Year	

Deductible Verification

Monthly Deductible Amount	\$ _____
Amount Verified as Met	\$ _____
Deductible Status	☐ Full Monthly Deductible Met

Attestation Statement

I certify that I am authorized to complete this verification on behalf of the Managed Care Organization (MCO). I have reviewed available information regarding the participant's deductible responsibility and verify that the amount listed above has been met, in whole or in part, through qualifying expenses. To the best of my knowledge, the information provided is accurate and complete.

Important Payroll Notice

Acumen Fiscal Agent of North Carolina must receive confirmation that deductible requirements have been satisfied before payroll services can be processed for the applicable service month. Incomplete or inaccurate information may result in processing delays and additional review.

MCO Representative Information

Representative Name	
Organization	
Phone Number	
Email Address	

Certification

Signature: _____

Date: _____

Contact Information

Email: ncmcoagents@acumen2.net
Fax: 855-264-3292