PROVIDER AND HOSPITAL CERTIFICATION MU OBJECTIVE 5: HEALTH INFORMATION EXCHANGE

Program Year: ______________________________

CEHRT Number: ______________________________

EHR Name ______________________________

- The undersigned provider hereby certifies that it has met the measure related to Meaningful Use Objective 5 (Health Information Exchange) associated with the attestation corresponding to the indicated program year in either of the following ways:
  - A combination of:
    - Creating and transmitting the summary of care document via electronic means using technology that complies with standards adopted by the Office of the National Coordinator for Health Information Technology (ONC) to a provider that can receive summaries of care in C-CDA format; or
    - Creating and transmitting the summary of care document via electronic means using secure e-mail, Health Information Service Provider (HISP), query-based exchange, or use of third party HIE. The provider must ensure that the transmission methods are in compliance with HIPAA requirements
      - **Note:** Faxing in general is **not** acceptable since is not in C-CDA format. It is only acceptable when a third party is used to transmit the summary of care record and they must convert the transmission to fax because that is the only way the receiving provider can accept the transmission. The conversion to fax by the third party must not be a default approach.
    - Qualifying for an exclusion as established in the CMS Stage 3 and Modifications to Meaningful Use in 2015 Through 2017 Final Rule (80 FR 62761). (**EP's only**)
- The provider understands it must retain documentary evidence supporting that the transmission of the summary of care document was successfully delivered to the receiving provider.

- I understand that the Puerto Rico MPIP (Medicaid Promoting Interoperability Program) can elect to review, verify and/or audit all information provided by me or on my behalf related to the MU general requirement herein, both prior to payment being issued and after an incentive payment has been made and/or as a result of a post payment audit process.
- I hereby certify that the foregoing information is true, accurate, and complete. I understand that the EHR incentive payments are made using Federal funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and Puerto Rico law.

Signature: ___________________________________ Date: ____________________

Provider/Hospital

Name ______________________ NPI: ____________________

For more information, visit the Puerto Rico State Level Registry (SLR) webpage at http://pr.arraincentive.com, call 787- 474-3300 or send your inquiries to mppipr@asespr.org