ATTENTION: Christine Guinn

RE: Medical School-Based Administrative Services claim for

Attached is the Medical School-Based Administrative Services claim prepared by:

A signed certification of a match letter is attached. Detailed documentation of claimable costs is available at this district’s administrative office.

If you have any questions concerning this claim please contact:

Sincerely,

Medicaid School Health Office
NM Human Services Department
Ark Plaza
Post Office Box 2348
Santa Fe, NM 87504
Medicaid Administrative Claiming (MAC) Invoice

This form serves as both the invoice and the certification of expenses of total computable and non-federal funds.

School District: ____________________________
Address: ___________________________________
Address2: ___________________________________
City: _______________________________________
State: _______________________________________
Zip: _________________________________________

<table>
<thead>
<tr>
<th>Cost Pool 1</th>
<th>Cost Pool 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Total Expenditures</td>
<td>75% FFP</td>
</tr>
<tr>
<td>2. Total Claimable Expenditures</td>
<td>$</td>
</tr>
<tr>
<td>3. Total Claimable Indirect Costs</td>
<td>$</td>
</tr>
<tr>
<td>4. Total Claimable Costs = (2+3)</td>
<td>$</td>
</tr>
<tr>
<td>5. Net Claimable (FFP x 4)</td>
<td>$</td>
</tr>
</tbody>
</table>

Total Net Claimable by Cost Pool $ $ $

Total Claimed $ $

I, as an authorized employee of the ________________________________, hereby certify that this LEA, REC or SFEA has expended the state share of public, non-federal funds needed to match the federal share of medical claims billed to the state Medicaid agency for School-Based Administrative Claiming services provided to eligible Medicaid students during the __________________________ quarter.

I also certify that this LEA’s, REC’s or SFEA’s certified expenditures were incurred in accordance with provisions of the New Mexico Medicaid Guide for School-Based Services. These certified expenditures are separately identified and supported in our accounting system made in a calendar quarter (Ex: Jan-Mar, April-June, July-Sept, Oct-Dec).

I am authorized by ________________________________ to submit this form and I have made a good faith effort to ensure that all the information reported is true and accurate.

Name: ____________________________ Date: ____________________________
Signature: ____________________________
Title: ____________________________

Medicaid Administrative Claiming (MAC) Program
Fairbanks LLC Release 001, Effective Q12011