COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT
AGENCY AND PRACTITIONER SELF-CERTIFICATION

This is to certify that:

Name: _____

Address: _____

_____

_____

Phone Number: ( ) _____

Agency Medicaid Number: _____ (if enrolled)

Practitioner Medicaid Number: _____ (if enrolled)

meets the qualifications to be a provider of comprehensive behavioral health assessment by providing documentation to the Medicaid area office staff who have verified that the agency or practitioner has met the qualifications as outlined in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook.

Begin date: _____ End date: _____

_____ _____

Provider Agency Representative Date

To complete the initial Medicaid provider enrollment process, submit this form with your Florida Medicaid Provider Enrollment Application to the address listed below.

Florida Medicaid Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070

AHCA Form 5000-3512, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)