

# COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT PROVIDER CERTIFICATION

This is to certify that

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone Number ( ) \_\_\_\_\_ Agency Medicaid Number \_\_\_\_\_(if enrolled)

has met the qualifications to be a provider of Comprehensive Behavioral Health Assessment by providing documentation to Substance Abuse and Mental Health staff who will provide this service to meet the qualifications as outlined in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations handbook.

Begin date: \_\_\_\_\_

End date: \_\_\_\_\_

\_\_\_\_\_ Date

District Substance Abuse and Mental Health Representative

**AND**

\_\_\_\_\_ Date

District Family Safety or Community Based Care Representative

**OR**

\_\_\_\_\_ Date

District Juvenile Justice Representative

**AND**

\_\_\_\_\_ Date

Area Medicaid Representative

Submit this form with your Florida Medicaid Provider Enrollment Application to the address listed below.

EDS  
Provider Enrollment  
P.O. Box 7070  
Tallahasee, FL 32314-7070