AGENCY CERTIFICATION
ADULT MENTAL HEALTH TARGETED CASE MANAGEMENT

Provider Agency Name: _____

Provider Agency Address: _____

_____

Provider Phone Number: ( ) Florida Medicaid Provider Number: _____

Is hereby certified to provide targeted case management services and meets all criteria as outlined in the Florida Medicaid Targeted Case Management Services Coverage Policy, incorporated by reference in Rule 59G-4.199, F.A.C.

_____

Provider Administrator: _____ Date: _____

_____

Area Medicaid Office Designated Representative: _____ Date: _____

All fee for service providers must have a fully executed certification form on file and all managed care organizations must ensure all certification criteria are met.