

AGENCY CERTIFICATION
INTENSIVE CASE MANAGEMENT TEAM SERVICES
ADULT MENTAL HEALTH TARGETED CASE MANAGEMENT

Provider Agency Name: _____

Provider Agency Address: _____

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

Meets the criteria for intensive case management team services 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.