**ALAMEDA COUNTY MENTAL HEALTH PLAN**

**SPECIALTY MENTAL HEALTH SERVICES**

**MANAGED CARE NETWORK PROVIDER ATTESTATION**

**EFFECTIVE July 1, 2016**

**Fax to Utilization Management (UM) Program: (888) 860-8068. Questions, call UM: (510) 567-8141**

|  |  |  |
| --- | --- | --- |
| **CLIENT NAME:**      | **DOB:**      | **CIN OR SSN:**      |

**Submit prior to 3rd session and within 60 days of initial visit. *\*Providers cannot provide treatment services before the client plan is completed.* Provider must initial each statement.**

|  |  |
| --- | --- |
| **PROVIDER INITIALS** | **PROVIDER CERTIFICATION** |
|       | I hereby certify that medical necessity has been met for Specialty Mental Health Services (SMHS) as specified by Medi-Cal (see Medical Necessity for SMHS on Providers Web Site – ACCESS Forms) and the Alameda County Mental Health Plan (MHP) moderate-to-severe criteria per the ACBHCS screening tool. |
|       | Date of 1st offered appointment: Click here to enter a date. Date of 1st face to face service: Click here to enter a date. |
|       | I certify that I have completed a full Assessment (Dated:\_Click here to enter a date.\_\_\_\_\_\_\_\_\_\_) and Client Plan (Dated:\_Click here to enter a date.\_\_\_\_\_\_\_\_\_\_), which meet the published QA standards, prior to delivering my first treatment service. These services are only Medi-Cal reimbursable when there is a completed client plan. |
|       | I certify that my Client Plan documents the need for the specific services provided and lists service modalities (e.g. psychotherapy, brokerage, collateral) as well as detailed interventions for each. |
|       | I agree to submit my Assessment and Client Plan for Utilization Review within a specified timeframe when requested by the Utilization Management Program.  |
|       | I acknowledge that I am subject to review or audit of my records and agree to keep up to date records.  |
|       | I certify that every claimed service has an individual progress note.  |
|       | I certify that services were medically indicated and necessary to the health of the client and were personally rendered by me or for an organization only, an employee under my direct supervision.  |
|       | I certify that all information provided is true, accurate, and complete. I understand that payment claims will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.  |

**PROVIDER/CLINICIAN INFORMATION**

**\_**     **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinician’s printed name Signature with discipline (e.g. PhD, LCSW, MFT, MD) Date**

**FOR LEVEL III ORGANIZATION USE ONLY**

     **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Organization Name**

 **If Clinician is not licensed, Licensed Supervisor’s Information is required on the line below:**

**\_\_**     **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Lic. Supervisor’s printed name Signature with discipline (e.g. PhD, LCSW, MFT, MD) Date**