Provider #:

_____

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH PLAN CLAIM CERTIFICATION FOR PROGRAM MANAGERS

I, _____ / _____**,** hereby certify that all claims submitted for
NAME TITLE

reimbursement under Short-Doyle/Medi-Cal are accurate, complete, and truthful, to the best of my knowledge and belief, and in compliance with all State and federal statutory and regulatory requirements, specifically:

- An assessment of the beneficiary was conducted in compliance with the requirements established in the Mental Health Program (MHP) contract with the Department.
- The beneficiary was eligible to receive Medi-Cal service(s) at the time the services were provided to the beneficiary.
- The services included in the claim were actually provided to the beneficiary.
- Medical necessity was established for the beneficiary for the service(s), for the timeframe in which the service(s) were provided.
- A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the MHP contract with the Department.
- For each beneficiary with day rehabilitation, day treatment intensive, or EPSDT supplemental specialty mental health services included in the claim, all requirements for MHP payment authorization in the MHP contract for day rehabilitation, day treatment intensive, and EPSDT supplemental specialty mental health service(s) were met, and any reviews for such service(s) were conducted prior to the initial authorization and any re-authorization periods as established in the MHP contract with the Department.

By signing my name below, I certify that all claims submitted from _____
FULL LEGAL NAME OF SITE

_____ / _____
FULL LEGAL NAME OF SITE PROVIDER #

for the month/year of _____ are to the best of my knowledge and belief, in full compliance with the requirements listed above. I further certify that all claims submitted for reimbursement are, to the best of my knowledge and belief, supported by documentation. I agree that I shall notify my appropriate chain of command supervisor in the event that I have any reason to believe that the grounds for certification of claims are no longer valid.

PROGRAM MANAGER (PRINT NAME)	SIGNATURE	DATE

As the individuals responsible for the oversight of the above named program(s), to the best of our knowledge and belief, processes are in place in the above referenced program(s) that are designed to monitor and ensure compliance with Short-Doyle/Medi-Cal claiming requirements.

MENTAL HEALTH CLINICAL PROGRAM MANAGER III (PRINT NAME)	SIGNATURE	DATE

DEPUTY DIRECTOR (PRINT NAME)	SIGNATURE	DATE

Comments and/or Changes: