COMMUNITY FIRST HEALTH PLANS

Targeted Case Management and Mental Health Rehabilitative Services Provider Training Attestation

_____ provides the following attestation as requested by
Provider Name

Community First Health Plans, Inc. (Community First) regarding the Mental Health Targeted Case Management and/or Mental Health Rehabilitative Services (TCM/MHR) (as defined by the Uniform Managed Care Contract) the Provider will render to Community First Members.

I, _____, attest on behalf of the Provider that to the best of
Provider Name

my knowledge the following is true and accurate.

- Provider has completed the applicable TCM/MHR training requirements outlined in the Uniform Managed Care Manual (UMCM) Chapter 15.3 (or its successor) before delivering any TCM/MHR services to Community First Members.
- Provider's licensed personnel who render TCM/MHR services have completed the training requirements outlined UMCM Chapter 15.3 (or its successor). Additionally, any personnel supervising clinicians delivering these services have completed these training requirements.

By signing below, I attest that I have carefully reviewed the information provided in this Attestation Statement and attest that is complete, accurate and truthful, and that I have the authority to sign this Attestation Statement on behalf of Provider. I understand that Provider's ability to join and/or remain in the Community First network is contingent upon the representations made in this attestation.

Provider Name: _____

Provider NPI: _____

Signature of Authorized Individual: _____

Authorized Individual Name *(please print)*: _____

Authorized Individual Title *(please print)*: _____

Date: _____

Please email completed forms to ***ProviderRelations@cfhp.com.***