Comprehensive Certification Form for Children Who Are Enrolled in Medicaid

Provider Enrollment and Provider Profile forms for this practice must be on file with the State Health Department or public health agency of record. Certification must be re-issued annually when provider profile is submitted.

Date: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: ( ) _____ Fax: ( ) _____

Email: _____

Authorizing Official: _____
(Please Print the Authorizing Official's Name)

_____
(Signature of Authorizing Official)

Retain a copy of this form at your facility and send the original to the State Health Department or state public health agency of record.