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SAN BERNARDINO COUNTY

**Behavioral Health**

**CaSonya Thomas, MPA, CHC**
Director

# MEDI-CAL ELIGIBLE
# CLAIMS CERTIFICATION AND PROGRAM INTEGRITY

**HEREBY CERTIFY** under penalty of perjury to the following:

1. An assessment of the beneficiary was conducted in compliance with the requirements established in the San Bernardino County Department of Behavioral Health Provider Manual and your Provider Service Agreement with San Bernardino County Department of Behavioral Health.
2. The beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the beneficiary.
3. The services included in the claim were actually provided to the beneficiary.
4. Medical necessity was established for the beneficiary as defined under Title 9, California Code of Regulations, Division 1, Chapter 11, for the service(s) provided, for the timeframe in which the service(s) were provided.
5. A client plan was developed and maintained for the beneficary that met all client plan requirements established in the San Bernardino County Department of Behavioral Health Provider Manual and your Provider Service Agreement with San Bernardino County Department of Behavioral Health.
6. For each beneficiary with day rehabilitation, day treatment intensive or EPSDT specialty mental health services included in the claim, all requirements for payment authorization for day rehabilitation, day treatment intensive and EPSDT supplemental speciality mental health services 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 Provider Manual and your Provider Service agreement with San Bernardino County Department of Behavioral Health.

By signing below, you are certifying that the above statements are true and that the services included in the claim were provided by you.

_____ _____

Authorized Provider Name (print) Date

_____

Signature of Authorized Provider