

Provider/Agency Name: _____

CERTIFICATION OF CLAIMS AND PROGRAM INTEGRITY FORM

Medi-Cal Eligible Certification of Claims and Program Integrity

I HEREBY CERTIFY under penalty of perjury to the following: An assessment of the beneficiary was conducted in compliance with the requirements established in the contract with the Riverside County Department of Mental Health (RCDMH) for Medi-Cal beneficiaries. The beneficiary was eligible to receive Medi-Cal services 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 as defined under Title 9, California Code of Regulations, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided. A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the contract with the RCDMH.

Signature of Authorized Provider

Date

Non-Medi-Cal Eligible Certification of Claims and Program Integrity

I HEREBY CERTIFY under penalty of perjury to the following: An assessment of the beneficiary was conducted in compliance with the requirements established in the contract with the Riverside County Department of Mental Health (RCDMH) for consumers who are referred by the Central Assess Team (CARES) or the Assessment and Consultation Team (ACT) for mental health specialty services. The beneficiary was referred to receive services at the time the services were provided to the beneficiary. The services included in the claim were actually provided to the beneficiary and for the timeframe in which the services were provided. A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the contract with the RCDMH.

Signature of Authorized Provider

Date