

**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: () _____

E-mail: _____

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.**