

**NC MEDICAID COMMUNITY BEHAVIORAL HEALTH TAXONOMY 251S00000X**

**PROVIDER ATTESTATION FORM**

**Provider name:** \_\_\_\_\_

**NPI:** \_\_\_\_\_

**Reference ID Number:** \_\_\_\_\_

When enrolling, re-enrolling, or completing re-credentialing/re-verification for taxonomy 251S00000X Community Behavioral Health, the Division of Health Benefits (DHB) must identify services being provided using this taxonomy. By completing this form, you are attesting that:

- Your services correspond with a procedure code within this taxonomy
- You are fully able to provide these services in the NC Medicaid program
- You are or will be contracting with at least one NC Behavioral Health Intellectual/Developmental Disabilities Tailored Plan (CDSA and ITP CBRS excluded)

Please select the service(s) under Community Intervention Services (CIS) you are able to provide or if you are not a CIS provider, please mark last box below:

	Services
	Ambulatory Detoxification
	Assertive Community Treatment Team (ACTT)
	Child and Adolescent Day Treatment (CADT)
	CIS Service Only
	Community Support Team
	Diagnostic Assessment
	Early Intervention Services
	Innovations Waiver Program
	Intensive in Home
	Medically Supervised or ADATC Detoxification/Crisis Stabilization
	Mobile Crisis Management
	Multisystemic Therapy (MST)
	Non-Hospital Detoxification
	Opioid Treatment
	Partial Hospitalization
	Peer Support Services
	Professional Treatment Services in Facility Based Crisis Program - Adult
	Professional Treatment Services in Facility Based Crisis Program - Child
	Psychosocial Rehabilitation
	Research Based – Behavioral Health Treatment (RB-BHT)
	Specialized Consultative Services
	Substance Abuse Comprehensive Outpatient Treatment

	Substance Abuse Intensive Outpatient Program
	Substance Abuse Medically Monitored Community Residential Treatment
	Substance Abuse Non-Medical Community Residential
	NO CIS SERVICES: COMMUNITY BEHAVIORAL HEALTH ONLY

The undersigned attests that the provider organization complies with all applicable requirements within NC Clinical Coverage Policies. The undersigned further acknowledges and understands that any material misrepresentation made to NC Medicaid regarding this Attestation may result in an investigation by NC Medicaid and/or impact the organization's eligibility to participate in the NC Medicaid program.

Printed Name of Office Administrator: \_\_\_\_\_

Signature of Office Administrator: \_\_\_\_\_

Date: \_\_\_\_\_