[Provider Name]
[CBH Child ID Number]
[Promise Enrollment Number]
[Address]
[Date]

[Provider Relations Representative Name]
Provider Relations Representative
Community Behavioral Health
801 Market Street, 7th Floor
Philadelphia, PA 19107

American Society of Addiction Medicine (ASAM) Level 3.7 Attestation

I, ____________________, attest to the accuracy of the response below. I also attest that [Provider Name] has met the following requirements, as a condition of serving Community Behavioral Health Members.

[Provider Name]'s non-hospital rehabilitation service meets criteria for ASAM Level 3.7, Medically Monitored Intensive Inpatient Services, as defined in The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Addition, 2013 (referred to from here as "ASAM Criteria") and specifically, that this service:

☐ Is located in the appropriate setting as defined in ASAM Criteria

☐ Provides the appropriate support systems as defined in ASAM Criteria

☐ Is staffed at the appropriate levels as defined in ASAM Criteria

☐ Provides the appropriate therapies as defined in ASAM Criteria

☐ Provides appropriate assessment/treatment plan review as defined in ASAM Criteria

☐ Completes appropriate documentation as defined in ASAM Criteria

I am aware that under the CBH Provider Agreement, I am only able to provide Covered Services to CBH Members if those services meet the minimum requirements set forth in the CBH Provider Agreement. Upon request by CBH, I am able to provide written verification of the attestations above.

____
Signature

____
Name

____
Title

____
Date