Commonwealth Of Pennsylvania
Office of Mental Health and Substance Abuse Services
Consolidated Community Reporting Initiative Attestation Form

****This form must be completed in its entirety by the identified Consolidated Community Reporting Initiative (CCRI) County Enrollment Contact Individual****

Name of the County: _____

CCRI County Enrollment Contact Name: _____
Print Name

_____ has successfully completed the CCRI
Name of Provider

process to enroll as a _____ provider.
Type of CCRI Service

Provider Type: ___ ___ Provider Specialty: ___ ___ ___

Service Location Address: _____
Street Address

_____ _____ _____
City State Zip Code

Providers who are enrolling for one of the following provider type (PT) and provider specialty (Spec) for ***base funded only*** services, ***please circle*** the corresponding PT/Spec and list the procedure code and modifier combination:

11-110	11-111	11-112	11-119	11-123	11-126	11-267
21-215	51-512	51-513	51-515	52-456	52-520	52-521
53-531	08-110 (only if enrolling for H2013)					

Procedure code _____ Modifier _____ _____ _____ _____

- ✓ The population to be served is consistent with the requirements for this service.
- ✓ The County has approved the enrollment of this provider for the CCRI program.

The requested effective date of the CCRI enrollment into PROMISe™ is _____,

_____ _____ _____
CCRI County Enrollment Contact Signature Printed Name Date

PLEASE NOTE: Services that fall under a provider type/provider specialty that is unlicensed, must submit a service description along with the application.

Updated 07/01/2019