Clear Form

Minnesota Department of **Human Services**

DHS-3864-ENG 9-13

Minnesota Health Care Programs (MHCP)

Mental Health Professional Applicant Assurance Statement – Medicare Enrollment Denial

Mental Health Professional Provider Information

PROVIDER NAME (LAST)	FIRST	MI	NPI

BUSINESS NAME (if applicable)

STREET ADDRESS

CITY	STATE	ZIP CODE	COUNTY

PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS
- -	- -	

DESIGNATED CONTACT NAME	DESIGNATED CONTACT PHONE NUMBER	DESIGNATED CONTACT EMAIL ADDRESS
	- -	

Applicant Assurance Statement

By signing this statement, I assure that I am not eligible to enroll as a Medicare provider and my education level has not changed since Medicare denied my enrollment.

PROVIDER SIGNATURE	DATE

Fax completed form to: 651-431-7462