Email or fax the completed form to:
CMS Provider Management
Email: cmsproviderhelp@flhealth.gov
Fax: (850) 487-1279

Request for CMS Medical Director Recommendation

_____ has applied to CMS for participation in the following practice area:

City/County: _____

Specialty/Sub-specialty: _____

Upon consideration of the above named physician, I make the following recommendation for CMS participation:

☐ I have professional knowledge of the above named physician and **recommend** him/her for approval for participation as a CMS provider.

☐ I have professional knowledge of the above named physician and **do not recommend** him/her for approval for participation as a CMS provider.

☐ I have **no knowledge** of the above named physician.

Comments (attach additional pages if necessary):

_____

_____

_____

CMS Medical Director's Information:

_____
Signature of CMS Medical Director

_____
Print Name of Medical Director

_____
Date

CMS Medical Director Type:
(Please check one.)

☐ CMS Plan Local

☐ CMS Plan Regional

☐ Child Protection Team

☐ Medical Foster Care

☐ Regional Perinatal Intensive Care