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