



# Northeast Behavioral Health

Online Education Course

## *Certificate*

### Denial, Limitation, or Reduction of Outpatient Medicaid Services

This is to certify that

\_\_\_\_\_ *Name*

at \_\_\_\_\_  
Facility Name, if applicable

NPI number: \_\_\_\_\_

successfully completed the above course.

Date: \_\_\_\_\_

By electronically signing and submitting this certificate, you are agreeing that you have completed this training, understand the information presented and will abide by the information presented.

Print a copy of this certificate for your records. If for any reason you are unable to submit this form electronically, fax this certificate to 970-392-1354 to the attention of the Education Coordinator.