MetroPlusHealth

Mental Health Provider Reimbursement Attestation

In accordance with New York State regulatory mandates, MetroPlus Health Plan requires certification that you will not seek reimbursement for Conversion Therapy provided to a member.

Please review, complete, sign and date the certification below:

I _____hereby certify that I will not seek reimbursement
(Print provider's name)

for Conversion Therapy provided to a MetroPlus member.

_____	_____
Provider's Signature	Print Provider's Name
_____	_____
Print Name of Group/Facility	Date Signed