Department of Health Care Finance

Health Care Operations Administration **Medicaid Primary Care Practitioners**

Self-Attestation Form (Page 1)

Department of Health Care Finance

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section I: Instructions** | | | | | | | | | | | |
| **The District of Columbia pays qualified providers for certain primary care and vaccine administration services at an enhanced rate that is equal to 100% of the Medicare fee schedule. The increased payment applies to both fee-for service and managed care claims. Practitioners who are paid through another provider such as hospital or federally-qualified health center are not eligible for the increased payment.**  **Eligible primary care providers include qualified Primary Care Physicians, Psychiatrists, Obstetricians/ Gynecologists (OB/GYNs) and Advanced Practice Registered Nurses (APRNs). To qualify for the increase in primary care payments, each physician must first self-attest that he/she is a physician with a specialty designation of family medicine, general internal medicine, pediatric medicine, obstetrics/gynecology, or psychiatry. In addition, each physician must self-attest that he/she is either Board-certified in an eligible specialty or that 60 percent of his/her Medicaid claims for the prior year (or for new practitioners, the prior month), were for the eligible Evaluation and Management (E &M) codes specified under DHCF rules. If you are a physician seeking the increased payment, you must complete Section II, IV and V of this form.**  **To qualify as an Advanced Practice Registered Nurses (APRNs), each APRN must self-attest that 60 percent of his/her Medicaid claims for the prior year (or for new practitioners, the prior month), were for the eligible Evaluation and Management (E &M) codes specified under DHCF rules. An APRN who practices under the supervision of an eligible physician may also be eligible for an increased payment rate. If you are an APRN seeking the increased payment based upon your supervising physician’s eligibility, your supervising physician must complete Section II, IV and V and you must complete section III. (Note: Physicians must complete a separate application form for each APRN under their supervision).On an annual basis, DHCF will review claims to verify that physicians and APRNS receiving higher payments meet the requirements for such payments. A false statement or false certification on this form may result in recoupment of any overpayments and prosecution for filing a false claim.**  **Note: Do not submit a new form if you are a primary care services provider who previously submitted a self-attestation form to DHCF and was eligible to receive the enhanced primary care rates in FY 15.** | | | | | | | | | | | |
| **Section II: Provider Information** | | | | | | | | | | | |
| DATE | | | | | PROVIDER NAME | | | | | | |
| BUSINESS STREET ADDRESS | | | | | CITY | | | | STATE | | ZIP CODE |
| COUNTY | PROVIDER TELEPHONE NO | | PROVIDER FAX NO | | | PROVIDER E-MAIL ADDRESS | | | | | |
| DESIGNATED CONTACT NAME | | DESIGNATED CONTACT PHONE NUMBER | | | | | | DESIGNATED CONTACT E-MAIL ADDRESS | | | |
| EIN NUMBER | NPI NUMBER | | MEDICAID PROVIDER NUMBER | | | | LICENSE NUMBER | | | STATE & DATE OF ISSUANCE | |
| Are you a Medicaid Managed Care Provider? Yes No | If so, please identify all DC Medicaid health plans in which you participate as a network provider: | |  | | | |  | | |  | |
| **Section III: Provider Information (For non-physicians practicing under the supervision of the physician named in Section II only)** | | | | | | | | | | | |
| DATE | | | | | PROVIDER NAME | | | | | | |
| BUSINESS STREET ADDRESS | | | | | CITY | | | | STATE | | ZIP CODE |
| COUNTY | PROVIDER TELEPHONE NO | | PROVIDER FAX NO | | | PROVIDER E-MAIL ADDRESS | | | | | |
| DESIGNATED CONTACT NAME | | DESIGNATED CONTACT PHONE NUMBER | | | | | | DESIGNATED CONTACT E-MAIL ADDRESS | | | |
| EIN NUMBER | NPI NUMBER | | | MEDICAID PROVIDER NUMBER | | | LICENSE NUMBER | | | STATE OF ISSUANCE | |
| Are you a Medicaid Managed Care Provider? Yes No | If so, please identify all DC Medicaid health plans in which you participate as a network provider: | | |  | | |  | | |  | |

DHCF (HCOA) 2016-03

441 4th Street, NW

Washington, DC 20001

(202) 727-5645 (fax)

[www.dc-medicaid.com](http://www.dc-medicaid.com/) [www.dhcf.dc.gov](http://www.dhcf.dc.gov/)