 Department of Health Care Finance

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

Self-Attestation Form (Page 2)

Department of Health Care Finance

|  |
| --- |
| Section IV: Specialty Designation |
| **1. I affirm that I am a physician with a primary specialty designation of (Check all that apply):**  **(Full Name of Provider)**  **\_\_\_\_\_\_\_\_\_\_\_\_ Family Medicine**  **\_\_\_\_\_\_\_\_\_\_\_\_ General Internal Medicine**  **\_\_\_\_\_\_\_\_\_\_\_\_ Obstetrics/ Gynecology**  **\_\_\_\_\_\_\_\_\_\_\_\_ Psychiatry, or**  **\_\_\_\_\_\_\_\_\_\_\_\_ Pediatric Medicine**  **2. I further attest that I am Board certified in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I received my Board-certification on \_\_\_\_\_\_\_\_\_\_\_\_\_ from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and my certification is current and valid; or**  **3. I have furnished evaluation and management services and vaccine administration services related to one of the recognized primary care specialties using HCPCS Evaluation and Management Codes 99201through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 or their successors and these codes are equal to at least 60 percent of the Medicaid codes that I have billed during the twelve months preceding this application; or**  **4. I have been a Medicaid provider for less than 12 months and have furnished evaluation and management services and vaccine administration services related to one of the recognized primary care specialties using HCPCS Evaluation and Management Codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 or their successors and these codes are equal to at least 60 percent of the Medicaid codes that I have billed during the month preceding this application.**  **----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------**  **1. I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ affirm that I am an Advanced Practice Registered Nurse and**  **2. \_\_\_\_\_\_\_\_\_ have furnished evaluation and management services and vaccine administration services related to one of the recognized primary care specialties using HCPCS Evaluation and Management Codes 99201through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 or their successors and these codes are equal to at least 60 percent of the Medicaid codes that I have billed during the twelve months preceding this application; or**  **3. I have been a Medicaid provider for less than 12 months and have furnished evaluation and management services and vaccine administration services related to one of the recognized primary care specialties using HCPCS Evaluation and Management Codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 or their successors and these codes are equal to at least 60 percent of the Medicaid codes that I have billed during the month preceding this application.**    **4. I have furnished evaluation and management services and vaccine administration services related to one of the recognized primary care specialties using HCPCS Evaluation and Management Codes 99201through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 or their successors and these codes are equal to at least 60 percent of the Medicaid codes that I have billed during the twelve months preceding this application; or**  **5. I have been a Medicaid provider for less than 12 months and have furnished evaluation and management services and vaccine administration services related to one of the recognized primary care specialties using HCPCS Evaluation and Management Codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 or their successors and these codes are equal to at least 60 percent of the Medicaid codes that I have billed during the month preceding this application.** |
| **Section V: Self-Attestation** |
| **I attest, under penalties of perjury, that the information on this application form is true and correct to the best of my knowledge and that I meet the criteria as a primary care physician eligible to receive the increased payment for designated primary care services.**    **Print Name**    **Signature**    **Date**  **Completed forms should be mailed or emailed to:**  **Department of Health Care Finance**  **Provider Enrollment and Outreach Branch**  **441 4th Street, NW**  **Suite 1000 South**  **Washington, DC 20001**  **202-698-2000**  **Email:** [**dhcf.providerenrollment@dc.gov**](mailto:dhcf.providerenrollment@dc.gov) |

DHCF (HCOA) 2012-11

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/)

DHCF (HCOA) 2016-03