Department of Health Care Finance
609 H Street, NE
Washington, DC 20002
(202) 727-5645 (fax)
www.dc-medicaid.com
www.dhcf.dc.gov

Department of Health Care Finance
Health Care Operations Administration

Medicaid Primary Care Practitioners

Self-Attestation Form (Page 1)

Section I: Background and Instructions

Effective for dates of service on or after January 1, 2013 through December 31, 2014, the District of Columbia is required by federal law to reimburse qualified physicians for certain primary care and vaccine administration services at the rate that would have been paid if the service was covered under Medicare. The increased payment applies to both fee-for service and managed care claims. Physicians who are paid through another provider such as hospital or federally-qualified health center are not eligible for the increased payment.

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, or pediatric medicine. In addition, each physician must self-attest that he/she is either Board-certified in an eligible specialty or eligible subspecialty and /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 federal rules. Eligible family medicine, general medicine and pediatric medicine subspecialties include only those recognized by the American Board of Medical Specialists (ABMS), the American Board of Physician Specialists (ABPS), and the American Osteopathic Association (APPS). (For a complete list of eligible subspecialties, see Attachment 1).

If you are a physician seeking the increased payment, you must complete Section II, IV and V of this form.

Advanced Practice Registered Nurses (APRNs) who practice under the direct supervision of an eligible physician may also be eligible for an increased payment based upon the increased Medicare rate. (Note: 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 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.

EFFECTIVE DATE OF PAYMENTS: Enhanced payment rates shall be paid for claims submitted on or after the date upon which DHCF receives the self-attestation form from an eligible provider. To be eligible for enhanced payment rates for claims retroactive to January 1, 2013, an eligible physician must submit the self-attestation form no later than July 1, 2013. Note – increased payments (including retroactive payments) will not be made until DCHF receives needed approvals from the Centers for Medicare and Medicaid Services (CMS). DHCF estimates this will occur in late summer, 2013. Additional information about this program is available at www.dhcf.gov or by calling Provider Services at: (202) 698 - 2000.

Section II: Provider Information (For Physicians 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 TAXONOMY CODE	MEDICAID PROVIDER NUMBER	LICENSE NUMBER	STATE & DATE OF ISSUANCE
Are you a Medicaid Managed Care Provider? Yes ____No____	If yes, please list the names of the plan(s) in which you participate.			

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 TAXONOMY CODE	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:			

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Section IV: Specialty Designation

1. I, _____,affirm that I am a physician with a primary specialty designation of
(Full Name of Provider)

(Check all that apply):

_____ Family medicine
_____ General internal medicine
_____ Pediatric medicine

2. _____I further attest that I am Board certified in _____ (please specify one of the recognized specialties or subspecialties identified in attachment A). 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 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 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.

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 faxed to:

Department of Health Care Finance
Provider Enrollment and Outreach Branch
609 H Street, NE
Washington, DC 20002
202-698-2000
202-727-5645 (fax)

DEADLINE FOR SUBMISSION: DHCF must receive all self-attestation forms from current providers no later than Monday, July 1, 2013.

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American Board of Medical Specialties and Subspecialty Certificates

General Certificate(s)	Subspecialty Certificates
Family Medicine	Adolescent Medicine* Geriatric Medicine* Hospice and Palliative Medicine* Sleep Medicine* Sports Medicine*
American Board of Internal Medicine	
Internal Medicine	Adolescent Medicine* Advanced Heart Failure and Transplant* Cardiology* Cardiovascular Disease* Clinical Cardiac Electrophysiology* Critical Care Medicine* Endocrinology* Diabetes and Metabolism* Gastroenterology* Geriatric Medicine* Hematology* Hospice and Palliative Medicine* Infectious Disease* Interventional Cardiology* Medical Oncology* Nephrology* Pulmonary Disease* Rheumatology* Sleep Medicine* Sports Medicine* Transplant Hepatology*
Pediatrics	Adolescent Medicine* Child Abuse Pediatrics* Developmental-Behavioral Pediatrics* Hospice and Palliative Medicine* Medical Toxicology* Neonatal-Perinatal Medicine* Neurodevelopmental Disabilities* Pediatric Cardiology* Pediatric Critical Care Medicine* Pediatric Endocrinology* Pediatric Gastroenterology* Pediatric Hematology-Oncology* Pediatric Infectious Diseases*Pediatric Nephrology* Pediatric Pulmonology* Pediatric Rheumatology* Pediatric Transplant Hepatology* Sleep Medicine*Sports Medicine
Source: http://www.certificationmatters.org/about-board-certified-doctors/whats-so-special-about-specialties/listing-of-board-certified-specialties.aspx	

American Osteopathic Association (AOA) Specialties & Sub-Specialties

CERTIFYING BOARD	PRIMARY CERTIFICATION	CERTIFICATION OF SPECIAL QUALIFICATIONS (CSQ)
Family Physicians	Family Medicine and OMT **	None offered
Internal Medicine	Internal Medicine	Allergy/Immunology* Cardiology* Endocrinology* Gastroenterology* Hematology* Hematology/Oncology* Infectious Disease* Pulmonary Diseases* Nephrology* Oncology* Rheumatology*
Pediatrics	Pediatrics	Adolescent & Young Adult* Neonatology* Pediatric Allergy/Immunology
		Pediatric Endocrinology* Pediatric Pulmonology*
Source: http://www.osteopathic.org/inside-aoa/development/aoa-board-certification/Pages/specialty-subspecialty-certification.aspx		

The American Board of Physician Specialties

List of Specialties	Sub-Specialties
• Family Medicine Obstetrics • Family Practice • Internal Medicine	None listed
Source: http://www.abpsus.org/abps-medical-board-certifications	

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