

Primary Care Enhanced Payment Self-Attestation

Provider Information	This form is for providers who believe they are eligible for an enhanced rate based on their specialty or billing history. Provider Name _____ Contact Information (In the event that we have questions regarding the information provided.) Telephone _____ E-Mail Address _____ Provider Type <input type="checkbox"/> Mid-Levels. No specialty required; however, their supervising provider name/signature is required. The supervising provider must meet the requirements for and be enrolled in the Primary Care Enhanced Payment Program. For more information, see the provider notice on the Enhanced Payment page of the website. <input type="checkbox"/> Physicians. (1) Indicate your applicable board designation and include a copy of the current certificate; (2) Indicate qualifying information: your board specialty and/or that you meet the required threshold; and (3) Check appropriate box for subspecialty.					
	Certifying Board (1)	Check the organization that recognizes your specialty designation, and attach a copy of your current certificate. If "Other" is selected in this section, the provider must qualify through the 60% threshold. See the Enhanced Payment page of the website for the list. <input type="checkbox"/> American Board of Physician Specialties (ABPS) <input type="checkbox"/> American Board of Medical Specialties (ABMS) The ABPS does not certify subspecialists. Eligible certifications are: <input type="checkbox"/> American Osteopathic Association (AOA) <input type="checkbox"/> American Board of Family Medicine Obstetrics <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Board of Certification in Family Practice <input type="checkbox"/> Board of Certification in Internal Medicine <input type="checkbox"/> As requested, I have attached a copy of my current , qualifying board certificate.				
Qualifying (2)		Defined Physician Specialties <input type="checkbox"/> Family Medicine <input type="checkbox"/> General Internal Medicine <input type="checkbox"/> Pediatric Medicine AND/OR Threshold <input type="checkbox"/> I meet the required threshold. At least 60% of my Medicaid billing services are E/M or vaccine administration. I do not have one of the defined specialties. My specialty is: _____				
	Subspecialty (3)	<input type="checkbox"/>	Adolescent Medicine	<input type="checkbox"/>	Hematology/Oncology	<input type="checkbox"/>
<input type="checkbox"/>		Adolescent / Young Adult Medicine	<input type="checkbox"/>	Hospice and Palliative Medicine	<input type="checkbox"/>	Pediatric Gastroenterology
<input type="checkbox"/>		Advanced Heart Failure	<input type="checkbox"/>	Infectious Disease	<input type="checkbox"/>	Pediatric Hematology Oncology
<input type="checkbox"/>		Allergy/Immunology	<input type="checkbox"/>	Interventional Cardiology	<input type="checkbox"/>	Pediatric Infectious Diseases
<input type="checkbox"/>		Cardiology	<input type="checkbox"/>	Medical Oncology	<input type="checkbox"/>	Pediatric Nephrology
<input type="checkbox"/>		Cardiovascular	<input type="checkbox"/>	Medical Toxicology	<input type="checkbox"/>	Pediatric Pulmonology;
<input type="checkbox"/>		Child Abuse Pediatrics	<input type="checkbox"/>	Neonatal-Perinatal Medicine	<input type="checkbox"/>	Pediatric Rheumatology
<input type="checkbox"/>		Clinical Cardiac Electrophysiology	<input type="checkbox"/>	Neonatology	<input type="checkbox"/>	Pediatric Transplant Hepatology
<input type="checkbox"/>		Critical Care Medicine	<input type="checkbox"/>	Nephrology	<input type="checkbox"/>	Pulmonary Disease
<input type="checkbox"/>		Developmental-Behavioral Pediatrics	<input type="checkbox"/>	Neurodevelopmental Disabilities	<input type="checkbox"/>	Rheumatology
<input type="checkbox"/>		Endocrinology	<input type="checkbox"/>	Oncology	<input type="checkbox"/>	Sleep Medicine
<input type="checkbox"/>		Endocrinology, Diabetes and Metabolism Disease	<input type="checkbox"/>	Pediatric Allergy/Immunology	<input type="checkbox"/>	Sports Medicine
<input type="checkbox"/>		Gastroenterology	<input type="checkbox"/>	Pediatric Cardiology	<input type="checkbox"/>	Transplant Cardiology
<input type="checkbox"/>		Geriatric Medicine	<input type="checkbox"/>	Pediatric Critical Care Medicine	<input type="checkbox"/>	Transplant Hepatology
<input type="checkbox"/>		Hematology	<input type="checkbox"/>	Pediatric Emergency Medicine	<input type="checkbox"/>	Other (Specify) _____
Signatures		Supervising provider name and signature required for mid-level practitioners. I attest through signature that the above specialty, subspecialty designation, and certifying board information to be true and accurate.				
	Provider _____	Provider Printed Name	Supervising Provider _____	Supervising Provider Printed Name		
	Provider NPI _____	Provider Signature	Provider NPI _____	Supervising Provider Signature		

These enhanced payments will not begin for a provider until the completed form and current board certificate are received. Complete the form, print, sign, and mail all documentation to: Provider Relations Manager • Xerox State Healthcare, LLC • P.O. Box 4936 • Helena, MT 59604.

If you have questions about completing this form, contact Provider Enrollment at 1.800.624.3958 or 406.442.1837.