

# Alabama Medicaid Primary Care Enhanced Physician Rates “Bump” Certification and Attestation Form

This form is to be completed by an individual physician with a primary specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine to attest to his/her eligibility<sup>1</sup> to receive the Alabama Medicaid Primary Care Enhanced Rate. **The provider attesting shall include the Medicaid provider number(s) for each location to be considered for the enhanced payment at each practice.**

**Submit ORIGINAL form to: Gainwell Technologies, PO Box 241685, Montgomery, Alabama 36124**

All information must be complete and easy to read. Please retain copy for your records.

## SECTION 1: Primary Care Information

Primary Care Provider Name: \_\_\_\_\_ Primary Care Provider Individual NPI: \_\_\_\_\_  
 Primary Care Provider Medicaid #(s): \_\_\_\_\_

**Physicians:** Please list the NPI(s) of all the nurse practitioners and/or physician assistants you supervise and assume professional responsibility for, this allows these practitioners to receive the fee enhancement for eligible<sup>1</sup> services:

1. Practitioner Name: \_\_\_\_\_ NPI: \_\_\_\_\_ Medicaid Provider#(s) \_\_\_\_\_
2. Practitioner Name: \_\_\_\_\_ NPI: \_\_\_\_\_ Medicaid Provider#(s) \_\_\_\_\_
3. Practitioner Name: \_\_\_\_\_ NPI: \_\_\_\_\_ Medicaid Provider#(s) \_\_\_\_\_

## SECTION 2: Attestation

I attest that I am eligible<sup>1</sup> for the enhanced payment because I am a physician as defined in 42 CFR § 440.50 practicing one of the following specialties or subspecialty designations recognized by the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS), or American Osteopathic Association (AOA): (initial here and select option below). *Initial:* \_\_\_\_\_

Family Medicine     General Internal Medicine     Pediatrics    List subspecialty(ies) (if applicable): \_\_\_\_\_

To qualify for the rate enhancement, the provider must additionally meet the national board certification requirements in Section 2A or the 60% paid Medicaid procedures billed requirement in Section 2B. Provider to complete **ONLY** the Section that applies.

### SECTION 2A: National Board Certification

*Complete Section 2A if you have a certification from the ABMS, ABPS, or AOA. Attach a copy of provider's certification (web-verification print out) to attestation form.*

National Board Certification: (please indicate one) <input type="checkbox"/> ABMS <input type="checkbox"/> ABPS <input type="checkbox"/> AOA	Certification Begin Date: _____	Certification End Date: _____	Certification Number _____
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I attest that I have current certification recognized by the ABMS, ABPS, or AOA and that I am eligible<sup>1</sup> to receive the enhanced payment. If my board certification expires, I understand that I must resubmit this attestation for the rate enhancement upon recertification by an aforementioned recognized entity; services provided during breaks in board certification expiration and attestation will not be eligible<sup>1</sup> for the rate enhancement. I will notify Gainwell within 10 days if my board certification expires. *Initial:* \_\_\_\_\_

### SECTION 2B: 60% Paid Medicaid Procedures Billed Attestation

*Complete Section 2B if you do not have a certification from the ABMS, ABPS, or AOA, however, you are practicing in the fields of family medicine, general internal medicine, pediatrics or a subspecialty recognized by the ABMS, ABPS or AOA and at least 60% of your paid Medicaid procedures billed are for certain<sup>1</sup> procedure codes for evaluation and management (E&M) services and certain<sup>1</sup> Vaccines for Children (VFC) vaccine administration codes specific to each practice location. Select one of the options below:*

I am currently enrolled as a Medicaid Primary Care Provider (with claims history on file).

I attest that at least 60% of my paid Medicaid procedures billed for the previous calendar year were for certain<sup>1</sup> procedure codes for evaluation and management (E&M) services, and certain<sup>1</sup> Vaccines for Children (VFC) vaccine administration codes, and that I am eligible<sup>1</sup> for the enhanced payment. *Initial:* \_\_\_\_\_

I am a new Medicaid Primary Care Provider (with at least one full month of claims history on file).

I attest that at least 60% of my paid Medicaid procedures billed for the prior month were for certain<sup>1</sup> procedure codes for evaluation and management (E&M) services and certain<sup>1</sup> Vaccines for Children (VFC) vaccine administration codes, and that I am eligible<sup>1</sup> for the enhanced payment. *Initial:* \_\_\_\_\_

**I understand that upon a claims audit, if my individual claims volume does not meet the 60% threshold, enhanced payments may be subject to recoupment by the Alabama Medicaid Agency.**

## SECTION 3: All Providers

I affirm, under the penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. If I lose board certification in one of the approved specialties and/or subspecialties, or such certification expires and is not renewed, it is my obligation to notify Gainwell of my board certification end date. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein. By submitting this application, I acknowledge that I have read and agree to the rules set forth, to gain eligibility<sup>1</sup> to receive enhanced payments. Therefore, my signature indicates that I have legal authority to submit self-attestation and understand that my written signature is binding.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

<sup>1</sup> As defined by 42 C.F.R. Pts.438, 441, and 447, interpreted by Centers for Medicare and Medicaid (CMS) guidance and consistent with the Alabama State Plan