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[1] 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: DXC, 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[1] 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[1] 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 subspecialtie(s) (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)	Certification Begin Date:	Certification End Date:	Certification Number
☐ ABMS ☐ ABPS ☐ AOA			

☐ I attest that I have current certification recognized by the ABMS, ABPS, or AOA and that I am eligible[1] 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[1] for the rate enhancement. I will notify DXC 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[1] procedure codes for evaluation and management (E&M) services and certain[1] 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[1] procedure codes for evaluation and management (E&M) services, and certain[1] Vaccines for Children (VFC) vaccine administration codes, and that I am eligible[1] 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[1] procedure codes for evaluation and management (E&M) services and certain[1] Vaccines for Children (VFC) vaccine administration codes, and that I am eligible[1] 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 DXC 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[1] 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 : _____

[1] 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