

**Alabama Medicaid Agency**  
**Patient-centered Medical Home (PCMH) Recognition Attestation Form**

This form is to be completed by PCP Groups who are currently enrolled with Medicaid and who are actively participating with the Alabama Coordinated Health Network (ACHN) to attest PCMH Recognition (from JCAHO or other certifying entity) or progress (Agency determined level) toward PCMH Recognition.

Send this completed PCMH Attestation Form and attachments by **mail** to:

Alabama Medicaid Agency  
 Network Provider Assistance Unit  
 501 Dexter Avenue  
 P.O. Box 5624  
 Montgomery, Alabama 36103-5624

by **fax** to 334-353-3856

-OR-

by **e-mail** to [Travis.Houser@medicaid.alabama.gov](mailto:Travis.Houser@medicaid.alabama.gov) **AND**  
[Patricia.Toston@medicaid.alabama.gov](mailto:Patricia.Toston@medicaid.alabama.gov)

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

|  |                                 |                                     |
|--|---------------------------------|-------------------------------------|
| <b>SECTION 1: Primary Care Physician Group Information</b>   |                                 |                                     |
| Primary Care Physician Group Name: _____   |                                 |                                     |
| Primary Care Physician Group NPI: _____  |                                 |                                     |
| Primary Care Physician Group Medicaid #: _____   |                                 |                                     |
| The Primary Care Physician Group is actively participating with the following ACHN:<br>_____   |                                 |                                     |
| <b>SECTION 2: Attestation</b>  |                                 |                                     |
| I attest that the identified Primary Care Physician Group has achieved PCMH recognition or has made progress toward PCMH Recognition. I attest that I am actively participating with at least one of the seven ACHN Entities.  |                                 |                                     |
| Group representative initial here. <i>Initial</i> : _____  |                                 |                                     |
| <b>SECTION 2A: PCMH Recognition</b>  |                                 |                                     |
| <i>Complete this section about details of your PCMH Recognition or if you have made progress towards PCMH Recognition from the Joint Commission of Healthcare Organization (JCAHO) or other certifying agency. Attach proof of PCMH Recognition achievement or progress towards PCMH Recognition (web-verification print out) to attestation form.</i>   |                                 |                                     |
| Certifying PCMH Recognition Agency: (please indicate one)<br><input type="checkbox"/> JCAHO <input type="checkbox"/> Other (please specify): _____   | Certification Begin Date: _____ | Current Percentage Completed: _____ |
| I attest that I have current PCHM Recognition or have made at progress toward PCMH Recognition by JCAHO or other certifying agency. I understand that I must resubmit this attestation annually by August 1 <sup>st</sup> to receive PCMH Bonus Payment for the next fiscal year.  |                                 |                                     |
| Group Representative's Initial: _____  |                                 |                                     |
| <b>SECTION 3: Signature</b>  |                                 |                                     |
| 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. 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 attestation, I acknowledge that I have read and agree to the rules set forth, to gain eligibility to receive quarterly PCMH bonus 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 : _____  |                                 |                                     |
| E-mail: _____ Telephone # _____  |                                 |                                     |