Primary Care Provider

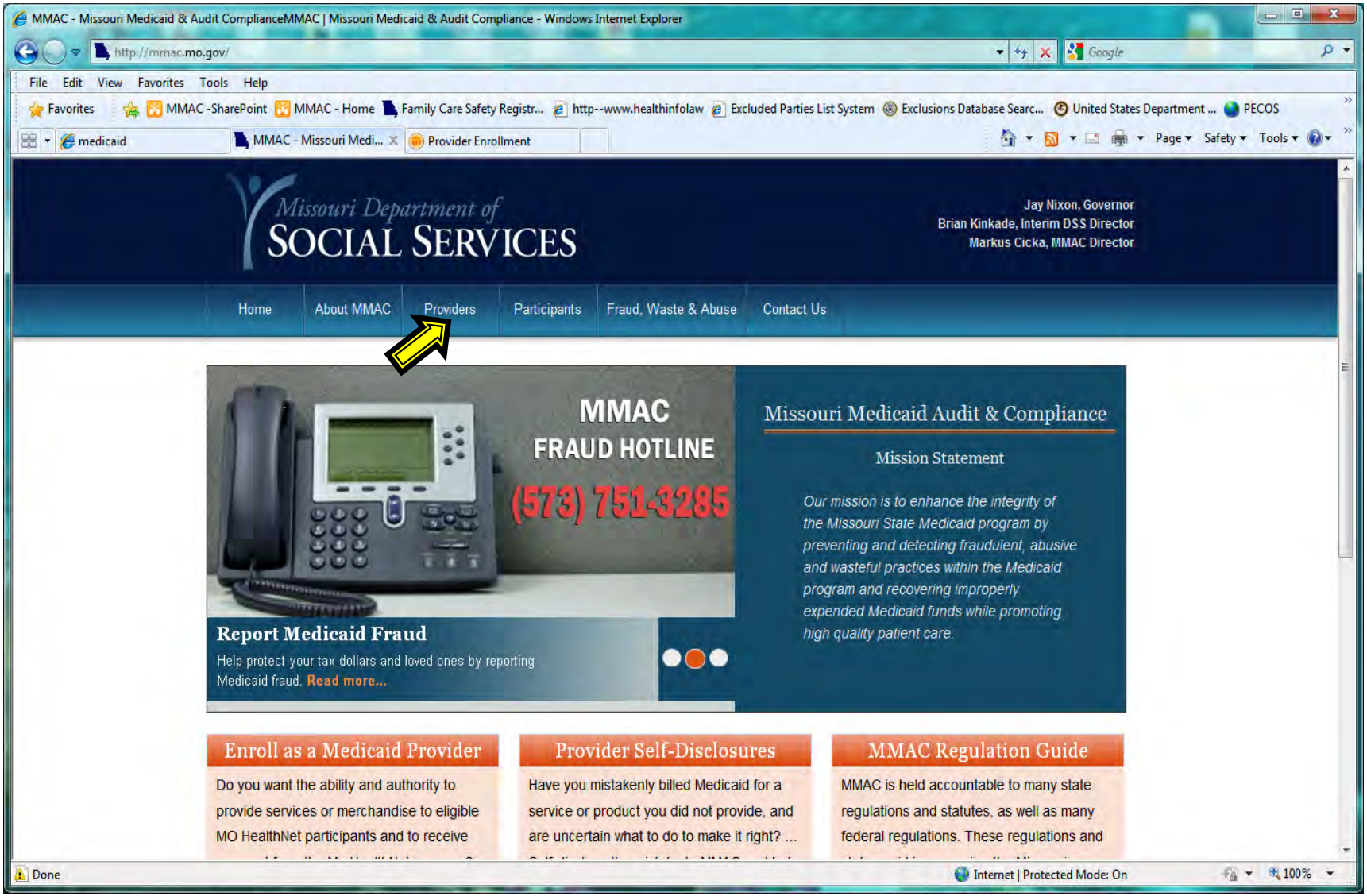
Certification Attestation

MMAC

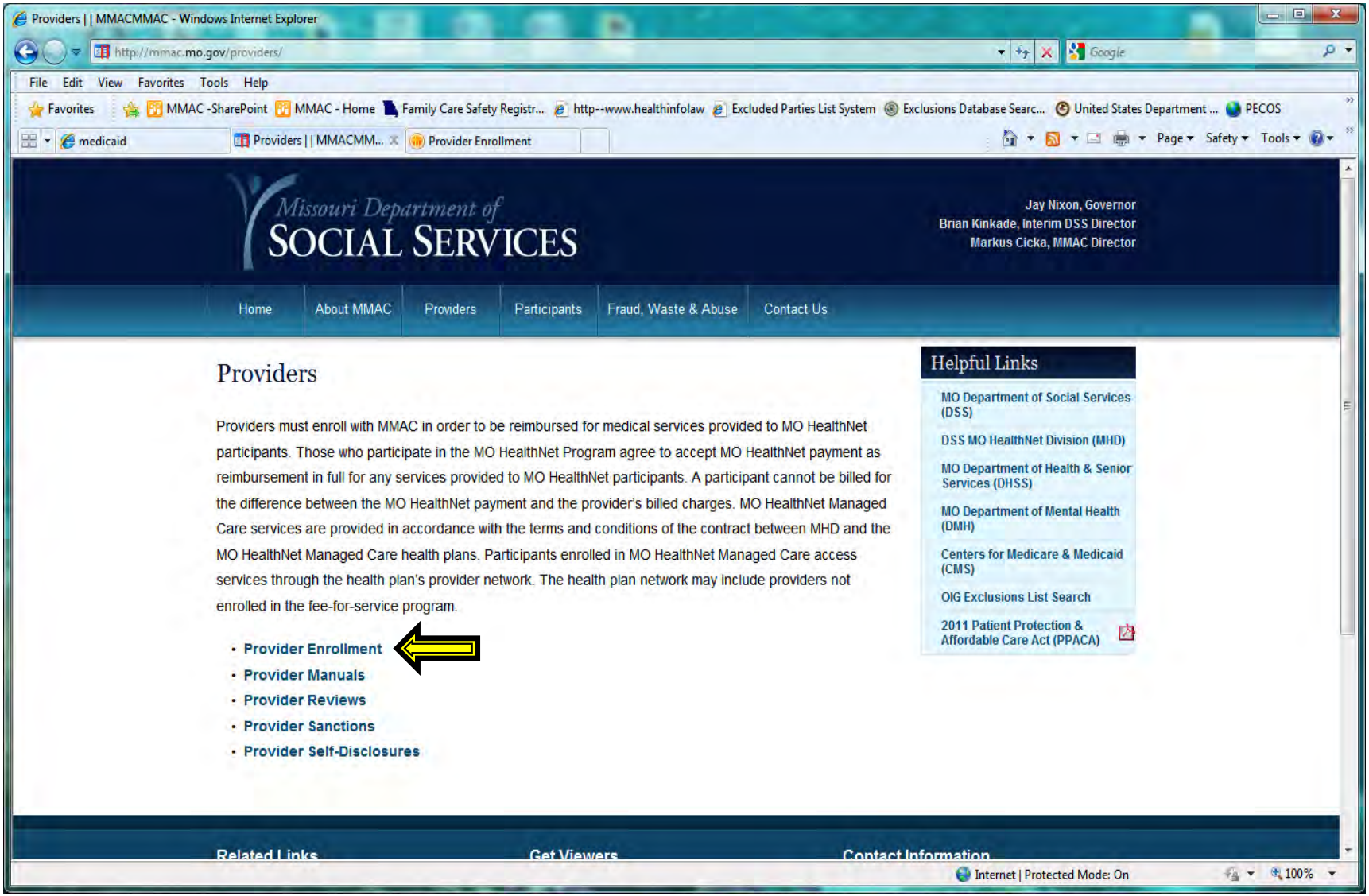
www.mmac.mo.gov

573-751-3399

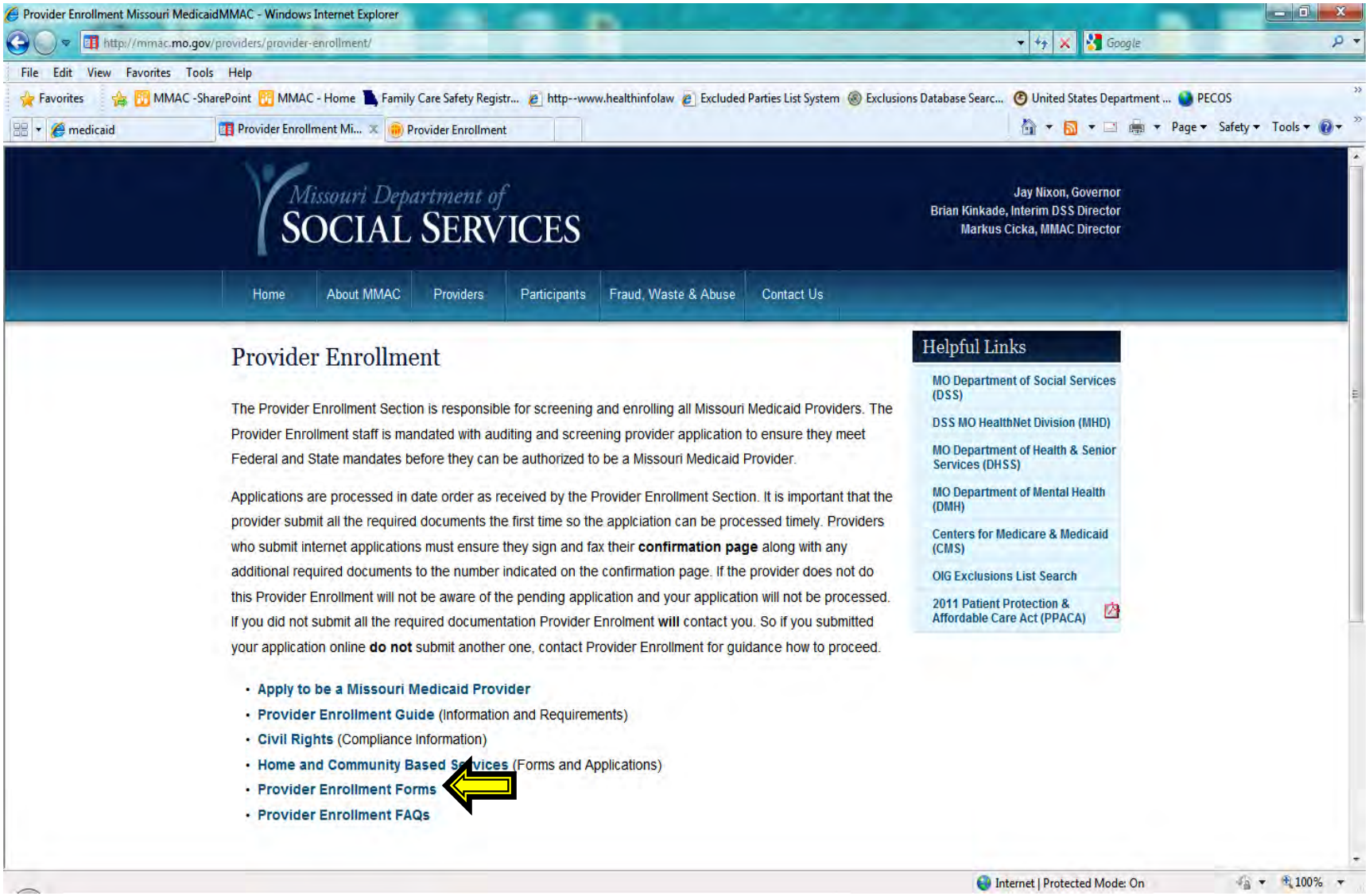
Log onto www.mmac.mo.gov



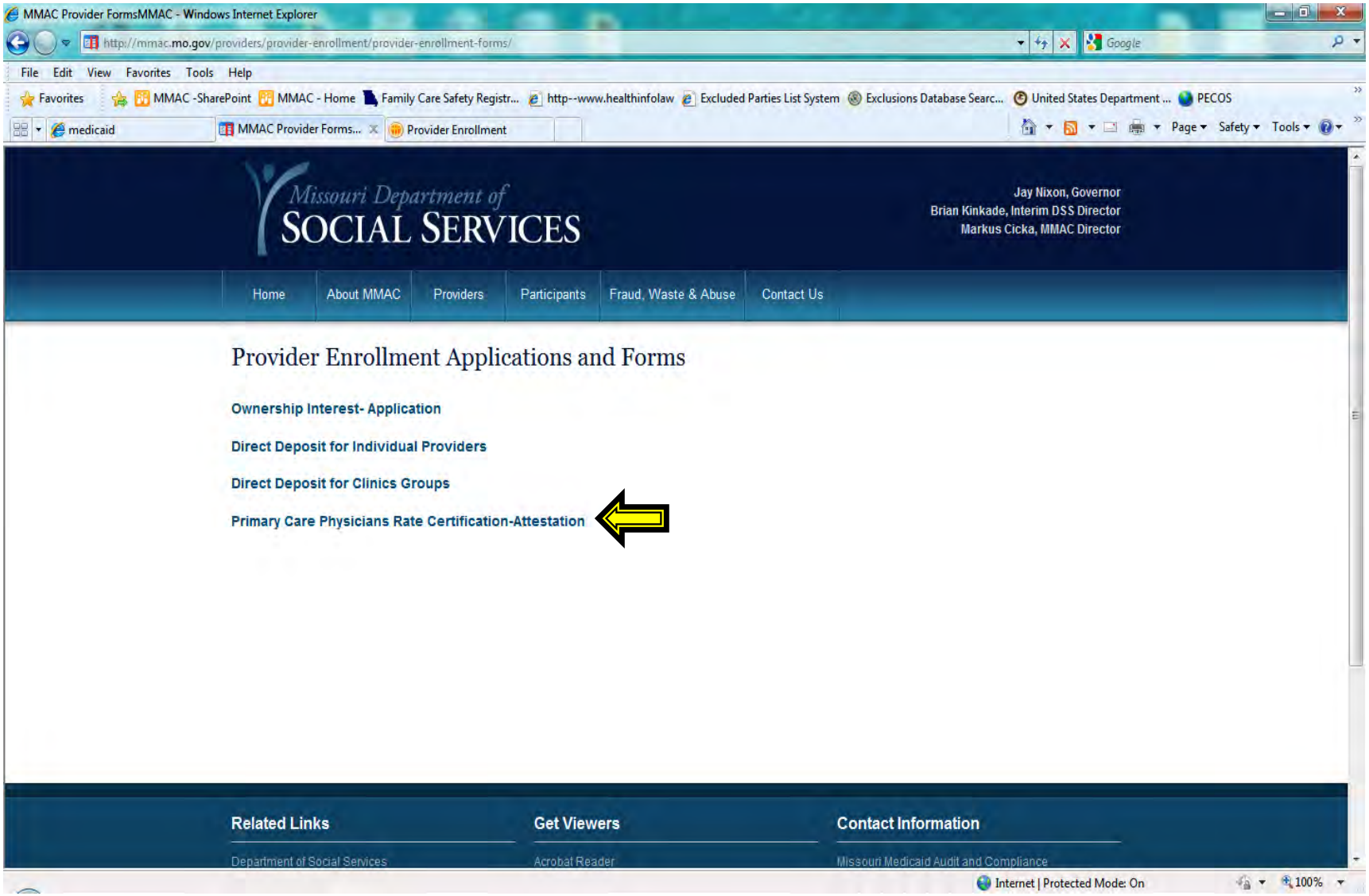
Click on the “Providers” tab



Click on “Provider Enrollment”

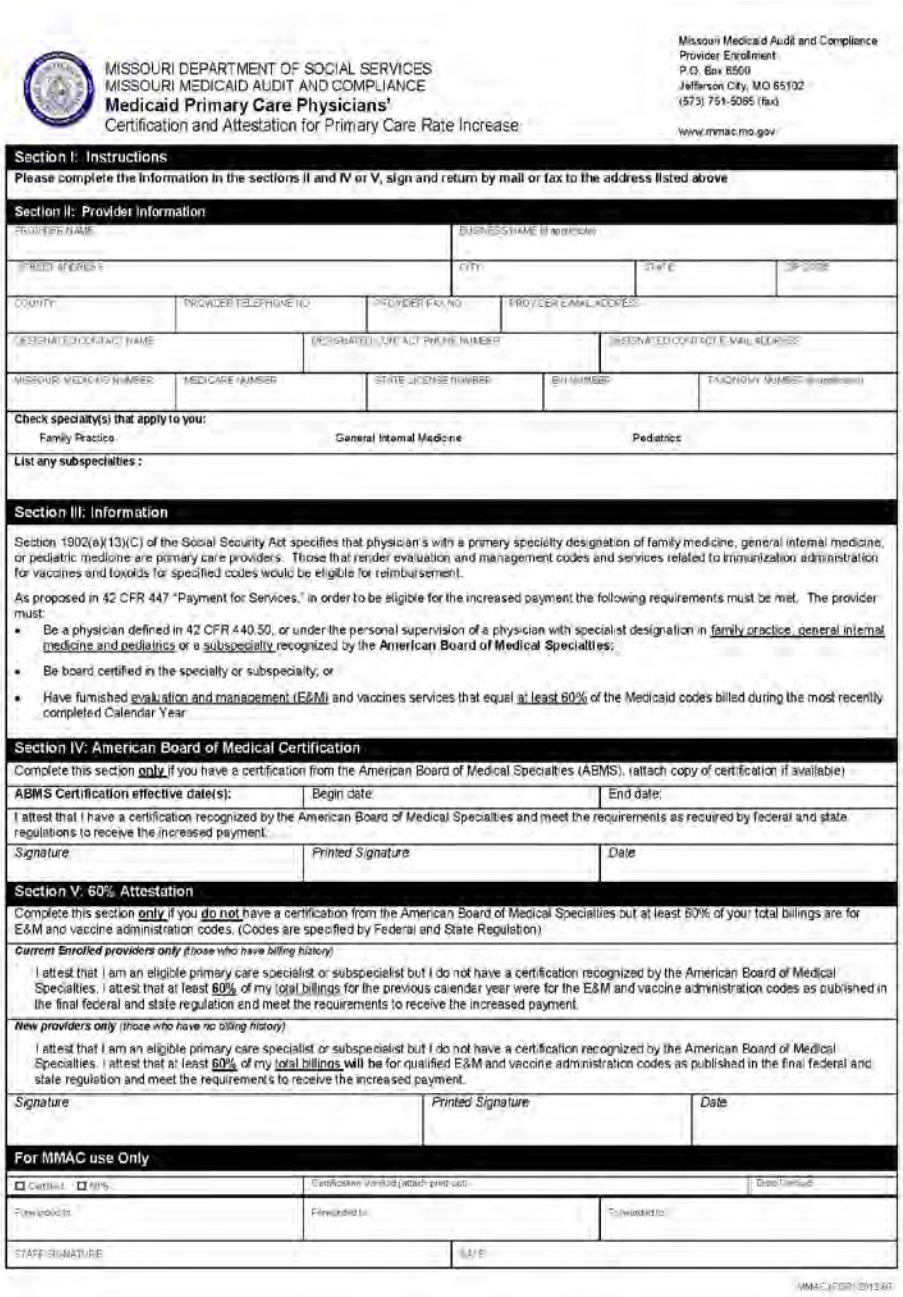


Click on “Provider Enrollment Forms”



Click on “Primary Care Physicians' Rate Certification- Attestation

Complete the information on the form and submit it to the address or fax number listed on the form.



MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE
Medicaid Primary Care Physicians'
Certification and Attestation for Primary Care Rate Increase

Missouri Medicaid Audit and Compliance
Provider Enrollment
P.O. Box 6500
Jefferson City, MO 65102
(573) 751-5065 (fax)

www.mmac.mo.gov

Section I: Instructions

Please complete the information in the sections II and IV or V, sign and return by mail or fax to the address listed above

Section II: Provider Information

PROVIDER NAME		BUSINESS NAME (if applicable)		
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	
MISSOURI MEDICAID NUMBER	MEDICARE NUMBER	STATE LICENSE NUMBER	BIN NUMBER	TAXONOMY NUMBER (if applicable)

Check specialty(s) that apply to you:

Family Practice General Internal Medicine Pediatrics

List any subspecialties :

Section III: Information

Section 1902(a)(13)(C) of the Social Security Act specifies that physician's with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine are primary care providers. Those that render evaluation and management codes and services related to immunization administration for vaccines and toxoids for specified codes would be eligible for reimbursement.

As proposed in 42 CFR 447 "Payment for Services," in order to be eligible for the increased payment the following requirements must be met. The provider must:

- Be a physician defined in 42 CFR 440.50, or under the personal supervision of a physician with specialist designation in family practice, general internal medicine and pediatrics or a subspecialty recognized by the **American Board of Medical Specialties**;
- Be board certified in the specialty or subspecialty; or
- Have furnished evaluation and management (E&M) and vaccines services that equal at least 60% of the Medicaid codes billed during the most recently completed Calendar Year

Section IV: American Board of Medical Certification

Complete this section **only** if you have a certification from the American Board of Medical Specialties (ABMS). (attach copy of certification if available)

ABMS Certification effective date(s):	Begin date:	End date:

I attest that I have a certification recognized by the American Board of Medical Specialties and meet the requirements as required by federal and state regulations to receive the increased payment.

Signature	*Printed Signature*	*Date*

Section V: 60% Attestation

Complete this section **only** if you **do not** have a certification from the American Board of Medical Specialties but at least 60% of your total billings are for E&M and vaccine administration codes. (Codes are specified by Federal and State Regulation)

Current Enrolled providers only *(those who have billing history)*

I attest that I am an eligible primary care specialist or subspecialist but I do not have a certification recognized by the American Board of Medical Specialties. I attest that at least **60%** of my total billings for the previous calendar year were for the E&M and vaccine administration codes as published in the final federal and state regulation and meet the requirements to receive the increased payment.

New providers only *(those who have no billing history)*

I attest that I am an eligible primary care specialist or subspecialist but I do not have a certification recognized by the American Board of Medical Specialties. I attest that at least **60%** of my total billings **will be** for qualified E&M and vaccine administration codes as published in the final federal and state regulation and meet the requirements to receive the increased payment.

Signature	*Printed Signature*	*Date*

For MMAC use Only

☐ Certified ☐ 60%	Certification Verified (attach print-out)	Date Certified
Forwarded to	Forwarded to	Forwarded to
STAFF SIGNATURE	DATE	

MMAC (FOR) 2012-07

- A completed form needs to be submitted for *every* provider who will be eligible for reimbursement
- The Provider Enrollment Section will verify and validate the information
- Enter the information into the MMIS Provider Master File
- MHD will pay providers accordingly

Contact Information

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