Telehealth Provider Attestation

AmeriHealth Caritas Florida

Provider Name: _____ Provider Tax ID Number (TIN):_____

AmeriHealth Caritas Florida provides coverage for services provided through telemedicine, when appropriate, for services covered under the Agency for Health Care Administration (AHCA) contract. Signing this attestation signifies your compliance with the requirements set forth by AHCA.

When treating AmeriHealth Caritas Florida members, be sure to include all of the following items in your documentation for services provided through telehealth:

☐ Medical records documentation, including a brief explanation of the use of telehealth in each progress note.

☐ Documentation of telehealth equipment used for the particular covered services provided.

☐ A signed statement from the patient or his/her authorized representative indicating their choice to receive services through telehealth. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided. Remember to bill telehealth services using the GT modifier, or other subsequent billing indicator as required by AHCA.

1. Provider type and specialty: Medical provider: Behavioral health provider:	
2. Our equipment and processes for providing telemedicine services are in compliance with the Health Insurance Portability and Accountability Act, other state and federal laws pertaining to patient privacy, technical standards required by 45 CFR §164.312, and Rule 59G-1.057 F.A.C.	☐ Yes ☐ No
3. We use two-way, real-time interactive communication between the patient and the physician at the distant site.	☐ Yes ☐ No
4. We use audio and video interaction with patient.	☐ Yes ☐ No
5. We educate the patient on the use of telemedicine and obtain consent.	☐ Yes ☐ No
6. We provide recipients the choice of whether to access services through a face-to-face or telemedicine visit with us.	☐ Yes ☐ No
7. We document the choice for telemedicine in the patient's medical record.	☐ Yes ☐ No
8. We will provide services to the same extent that services would be covered if provided through a face-to-face (in person) encounter with a practitioner.	☐ Yes ☐ No
9. We are responsible for all equipment required to provide telemedicine services.	☐ Yes ☐ No
10. We have protocols to prevent fraud and abuse and have protocols that address: (a) Authentication and authorization of users. (b) Authentication of the origin of the information. (c) The prevention of unauthorized access to the system or information. (d) System security, including the integrity of information that is collected, program integrity, and system integrity. (e) Maintenance of documentation about system and information usage.	☐ Yes ☐ No

I will follow the guidance provided by AHCA regarding any temporary or permanent changes to the requirements for the provision of telehealth services, to be in compliance with any changes made by AHCA.

I attest that I represent the practice under "Provider Name" above. I further attest that I am able to provide telehealth services to AmeriHealth Caritas Florida members and to the statements and answers above.

Printed name:	Title:	
Phone number:	Signature:	Date:

Please return to: **PNM_Inquiries@amerihealthcaritasfl.com**