CSHCS PHYSICIAN ATTESTATION

Children's Special Health Care Services (CSHCS) primary care providers (PCPs) supervise, coordinate, and provide primary care, initiate referrals for specialty care, maintain continuity of CSHCS enrollees' health care, and maintain the CSHCS enrollees' medical records. Each CSHCS PCP must attest in writing that they meet specific qualifications.

Medicaid Health Plans must obtain written consent that specifies the PCP and practice:

- Are willing to accept new CSHCS Enrollees with potentially complex health conditions.
- Regularly serve children or youth with complex chronic health conditions.
- Have a mechanism to identify children/youth with chronic health conditions.
- Provide expanded appointments when children have complex needs and require more time.
- Have experience coordinating care for children who see multiple professionals (pediatric subspecialists, physical therapists, behavioral health professionals, etc.).
- Have a designated professional responsible for care coordination for children who see multiple professionals.
- Provide services appropriate for Health Care Transition, including but not limited to the use of a transition assessment tool and adoption of a transition policy that is publicly posted and specifies the transition time frame, transition approach, and legal changes that take place in privacy and consent at age 18.

Please select the option below that applies to you and return this form with the Provider Enrollment Form to the Health Plan(s) you wish to credential with. If none of these options apply, you do not need to return the attestation. Payment is made to the medical group quarterly.

Provider currently serves special populations of (Required: check one or all that apply):

- ☐ Children or youth with complex chronic health conditions.
- ☐ Transition-aged youth or young adults with complex chronic health conditions.

If Attesting as a Medical Group: _____ Service Location NPI: _____

If Attesting as a Physician: _____ Rendering NPI: _____

Print Name: _____ Date: _____

Signature: _____

Please call the Medicaid Health Plan(s) you are credentialing with if you have any questions.