AUTISM EVALUATION PRACTITIONER (AEP)

Select one
Provider Type 431 (Ph.D.) Specialty 150
Provider Type 301 (MD) Specialty 150
Provider Type 302 (DO) Specialty 150

Attestation Template

Name of Agency ____________________________________________
Agency NPI ____________________________________________
Agency MAD Provider Number ______________________________

Contracted with:
[ ] Blue Cross/Blue Shield of New Mexico
[ ] Presbyterian Health Plan
[ ] Western Sky Community Care

Name of Practitioner ________________________________
Practitioner NPI ________________________________
Practitioner Medicaid Provider Number ____________

I, INSERT PRACTITIONER’S NAME, hereby attest that I meet the standards as set forth in the New Mexico Administrative Code (NMAC), MAD Supplement 19-04, and the Behavioral Health Policy and Billing Manual to render Applied Behavior Analysis (ABA) Stage 1 Services as an approved MAD-BHSD Autism Evaluation Practitioner (AEP).

I. I am a licensed______. Additionally, I meet all the following (A-E) requirements.
   A. I have experience in or knowledge of the medically necessary use of ABA and other empirically supported intervention techniques.
   B. I am qualified to conduct and document both a Comprehensive Diagnostic Evaluation and a Targeted Evaluation for the purposes of developing an ISP.
   C. I have advanced training and clinical experience in the diagnosis and treatment of ASD and related neurodevelopment disorders, including knowledge about typical and atypical child development and experience with variability within the ASD population.
   D. I have advanced training in differential diagnosis of ASD from other developmental, psychiatric, and medical disorders.
   E. I further attest that all provider criteria, as outlined in applicable rules of the New Mexico Administrative Codes, have been and will continue to be met. When requested, I will provide documentation substantiating training, experience, and licensure.

II. I have attached my current New Mexico practice board’s license. I will maintain my licensure throughout the time I render ABA Stage 1 services and provide MAD with license renewals prior to the expiration of my current one. I will report any change in my licensure status in-between renewals immediately to the Behavioral Health Services Division (BHSD) ABA Program Manager.

Print Name and Title, Date and Sign
AGENCY
If you are the sole owner of the agency, sign for yourself. If you co-own the agency, request one of the other owners to complete. If you work for an agency, please have someone such as the agency’s HR sign.

I, INSERT NAME of AGENCY OFFICIAL, hereby attest that INSERT PRACTITIONER’S NAME has presented documentation to substantiate his or her education and experience requirements as listed above and a copy of his or her current New Mexico license as a ________. The agency has placed a copy of INSERT PRACTITIONER’S NAME required education and experience as detailed above in his or her personnel file and will add all subsequent licensure renewals.

Print Name and Title, Date and Sign

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