Effective January 1, 2015, New Mexico Medial Assistance Division "Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians Program" implements higher Medicaid payments for primary care services by certain physicians beginning in calendar year (CY) 2015.

In order to receive the increased payment, a physician may self-attest that he / she:

(1) Is board certified and practices in a specialty designation of family medicine, general internal medicine, or pediatric medicine, or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA), or;

(2) Practices in a primary care specialty and attests to evaluation and management services and vaccine administration services that equal at least 60 percent of the Medicaid codes billed during the prior CY, or for newly eligible physicians, the prior month.

In order to be considered for the increased payment, providers must complete the following form:

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider NPI</th>
<th>Provider Medicaid ID(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Provider Name (group, clinic corporation, etc.)</td>
<td>Provider Group NPI number(s)</td>
<td>Provider Group Medicaid ID(s)</td>
</tr>
</tbody>
</table>

**EXTENDERS NOTE:** Physician extenders working under the direction of a qualifying physician may qualify based on that supervising physician's qualifications. Supervising physicians must also self-attest and qualify for this program and accept professional responsibility and legal liability for the Physician extender. Please check your provider type, initial the professional responsibility box, provide the physician's name and NPI number and have the supervising physician sign and date below. Extenders are responsible for providing MAD with updated information anytime there is a change with their supervising physician.

- [ ] 305 Physician Assistant
  - I practice under the direction of a supervising physician who accepts professional responsibility and legal liability for me *(please check).*

- [ ] 316 Certified Nurse Practitioner
  - Physician's name

- [ ] 320 Pharmacist Clinician
  - Physician's NPI

- [ ] 322 Certified Nurse Midwife
  - Supervising Physician's Signature

**I attest that I meet one of the following criteria: please check and complete either (1) or (2)**

1. [ ] I am certified in one of the following specialty by one of the boards below that is designated by CMS as eligible to receive the increased payment AND I practice in that specialty *(please check the board and the appropriate specialty or subspecialty).* Please attach a copy of the board certification document. The certification is in effect from: __________ to: __________

**CERTIFYING BOARD:**
- [ ] American Board of Medical Specialties (ABMS)
- [ ] American Osteopathic Association (AOA)

American Board of Physician Specialties (ABPS) no subspecialties but included the following eligible boards:
- [ ] American Board of Family Medicine Obstetrics
- [ ] Board of Certification in Family Practice
- [ ] Board of Certification in Internal Medicine

**SPECIALITIES:**
- [ ] Family Medicine
- [ ] Internal Medicine
- [ ] Pediatric Medicine

**Subspecialties:**
- [ ] Adolescent Medicine
- [ ] Adolescent and Young Adult Medicine
- [ ] Adult Congenital Heart Disease
- [ ] Advance Heart Failure
- [ ] Allergy/Immunology
- [ ] Cardiology
- [ ] Cardiovascular Disease
- [ ] Child Abuse Pediatrics
- [ ] Clinical Cardiac Electrophysiology
- [ ] Critical Care Medicine
- [ ] Developmental Behavioral Pediatrics
- [ ] Endocrinology, Diabetes & Metabolism
- [ ] Gastroenterology
- [ ] Geriatric Medicine
- [ ] Hematology
- [ ] Hematology Oncology
- [ ] Hospice and Palliative Medicine
- [ ] Infectious Disease
- [ ] Interventional Cardiology
- [ ] Medical Oncology
- [ ] Medical Toxicology
- [ ] Neonatal-Perinatal Medicine
- [ ] Neonatal
- [ ] Nephrology
- [ ] Neurodevelopmental Disabilities
- [ ] Oncology
- [ ] Pediatric Allergy/Immunology
- [ ] Pediatric Cardiology
- [ ] Pediatric Critical Care Medicine
- [ ] Pediatric Emergency Medicine
- [ ] Pediatric Endocrinology
- [ ] Pediatric Gastroenterology
- [ ] Pediatric Hematology-Onco
- [ ] Pediatric Infectious Diseases
- [ ] Pediatric Nephrology
- [ ] Pediatric Pulmonology
- [ ] Pediatric Rheumatology
- [ ] Pediatric Transplant Hepatology
- [ ] Pulmonary Disease
- [ ] Rheumatology
- [ ] Sleep Medicine
- [ ] Sports Medicine
- [ ] Transplant Hepatology
- [ ] Transplant Cardiology

*New Mexico HSD - Medical Assistance Division*
*Primary Care Increase Self-Attestation Form*
*January 1, 2015*
(2) ☐ I attest to having specified E&M services and vaccine administration services that equal at least 60% of the Medicaid codes I have billed during the prior CY, or for newly eligible physicians, the prior month **AND** I practice in one of the CMS designated primary care specialties: **(check one of the following)**

☐ Family Medicine ☐ General / Internal Medicine ☐ Pediatric Medicine

The following codes are considered by CMS to be E&M "primary care" codes: 99201-99205, 99211-99215, 99217-99226, 99231-99236, 99238, 99239, 99241-99245, 99251-99255, 99258, 99261, 99262, 99263, 99269, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99354-99357, 99381-99387, 99391-99397, 99431-99439, 99460-99469, 99471, 99472, 99475-99480 and 99490.

The following codes are the allowed vaccine administration codes for 60% threshold calculation purposes only: 90460, 90461, 90471, 90472, 90473, and 90474.

Whoever knowingly and wilfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws.

I understand that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law. **Original signature required.**

Printed Name | Signature | Date
--- | --- | ---

New Mexico Medicaid project staff may need to contact you regarding the completion of this form. Please list contact details.

Contact Person | Telephone Number | E-Mail Address
--- | --- | ---

**Return completed application to:**
Ellen Maestas-Waller
Ellen.Maestas-Waller@state.nm.us
Medical Assistance Division - Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348