Telemedicine Provider Attestation

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

1. Do you provide telemedicine services to Sunshine Health members? If "Yes", please select all that apply below and complete items 2 – 8 *(note: affirmative answers are required for items 2 – 8 to continue providing telemedicine services to Sunshine Health members).*			Yes ☐ No ☐
Primary Care by Pediatrician, General Practitioner or Family Practitioner		Neurology by board certified practitioner	
Licensed mental health clinician services		Psychiatry by board certified practitioner	
Cardiology by board certified practitioner		Pulmonology by board certified practitioner	
Endocrinology by board certified practitioner		Rheumatology by board certified practitioner	
Nephrology by board certified practitioner		Internist	
Other (please specify):			
2. Our equipment and processes for providing telemedicine services are in compliance with 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 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 are responsible for all equipment required to provide telemedicine services			Yes ☐ No ☐
9. Name of application used for telemedicine:			

I attest that I represent the practice under "Provider Name" above. I further attest to the statements and answers above.

Printed Name: _____ Title: _____

Phone Number: _____

Signature: _____ Date: _____

Please return to **SHProviderpartners@centene.com**

03/05/2020