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	☐
• Licensed mental health clinician services	☐
• Cardiology by board certified practitioner	☐
• Endocrinology by board certified practitioner	☐
• Nephrology by board certified practitioner	☐
• Neurology by board certified practitioner	☐
• Psychiatry by board certified practitioner	☐
• Pulmonology by board certified practitioner	☐
• Rheumatology 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 ☐

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

9/1/2018