Horizon Blue Cross Blue Shield of New Jersey*

Horizon NJ Health

210 Silvia Street
West Trenton, NJ 08628
Phone: (609) 718-9001
www.horizonNJhealth.com

Affordable Care Act (ACA) Self-Attestation Form

(As Amended by Section 1202 of the Health Care and Education Reconciliation Act [HCERA] of 2010)

This document will be used as a qualifier for physicians belonging to a NJ Medicaid Managed Care Network. To qualify, the physician must self-attest that he/she practices within a specialty designation of family medicine, general internal medicine, pediatric medicine or related sub-specialty; and that 60% of his/her Medicaid codes for the prior year (for new physicians, the prior month), were for the eligible codes outlined in the ACA's Section 1202.

Annually, a claims review shall be conducted to verify that physicians/advanced practice clinicians receiving higher payments meet the requirements for such payments. A false statement and/or certification on this document may result in recoupment of identified overpayments and prosecution for filing a false Medicaid claim.

Please complete a separate form for each business/practice address.
Please PRINT

SECTION I – Physician Information

Physician Name _____

Business Address _____**E-mail**_____

City/State/Zip _____ **County** _____

Phone _____ **Fax** _____

Active NPI number(s) _____ _____

_____ _____ _____

Taxonomy code _____ **NJ License number** _____

Tax ID # _____ **Social Security # (last 4 digits) -**_____

Name of Billing Entity: _____

_____

_____

_____

Please check each Managed Care Network that you participate in:

_____ **Horizon NJ Health** _____ **HealthFirstNJ**

_____ **Amerigroup** _____**United Healthcare Community Plan**

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SECTION II – Specialty Designation

I attest that (initial all that apply):

_____ I am currently engaged in the practice of medicine with a primary specialty designation of: **Family Medicine** **General Internal Medicine** **Pediatric Medicine**
(Please circle all that apply)

_____ I am currently engaged in the practice of medicine with the related sub-specialty _____, as defined by Section 1202 of the ACA, recognized by: **ABMS** **AOA** **ABPS** (Please circle)

SECTION III – Physician Self-Attestation

_____**I attest (by signature)** that in calendar year 2012, sixty percent (60%) or more of my Medicaid billed codes were for the E & M codes (99201 – 99499) and vaccine administration codes (90460, 90461, 90471, 90472, 90473, 90474 or their successors identified in Section1202 of the ACA.

_____ **I attest (by signature) that I am a new physician** and last month, sixty percent (60%) or more of my Medicaid billed codes were for the E & M codes (99201 – 99499) and vaccine administration codes (90460, 90461, 90471, 90472, 90473, 90474 or their successors identified in Section1202 of the ACA.

(_____) (_____)
Physician Signature Date Signed

(_____) (_____)
Physician Name – Please Print National Provider Identifier (NPI)

(_____)
Horizon NJ Health Provider ID Number

Return fax to: 609-583-3004. Attention: Provider ACA Attestation Group

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SECTION IV – Advance Practice Clinician (APC) Information: Advanced Practice Clinicians (APC) practicing in an eligible specialty/related sub-specialty while under the personal supervision of an eligible physician may be eligible for higher rates of reimbursement. Before seeking higher rates of reimbursement, the supervising physician must identify each APC in Section IV. Please provide the requested information for each APC providing eligible services at the business address identified on Physician Self-Attestation form while under your supervision. Section IV provides space for two APCs, if additional space is required, please copy this page, complete, sign and submit.

Non-Physician Provider Name _____

Provider type_____ **E-mail**_____

NPI number _____

Taxonomy Code _____ **NJ License Number**_____

Medicaid–managed care provider (Please check all that apply):

_____ **Horizon NJ Health** _____ **HealthFirstNJ**

_____ **Amerigroup** _____**United Healthcare Community Plan**

Non-Physician Provider Name _____

Provider type_____ **E-mail**_____

NPI number _____

Taxonomy Code _____ **NJ License Number**_____

Medicaid –managed care provider – please check all that apply:

_____ **Horizon NJ Health** _____ **HealthFirstNJ**

_____ **Amerigroup** _____**United Healthcare Community Plan**

The above-named Advanced Practice Clinician(s) provide services that are eligible for enhanced reimbursement while working under my personal supervision at the location identified below.

_____**Physician Signature** _____**Date**

_____**Print Name**

Physician NPI Number(s) _____

_____

_____**Office Address**

_____**City/Zip Code**

Return fax to: 609-583-3004. Attention: Provider ACA Attestation Group