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**2014 Enhanced Payment Provider Self Attestation Form**

This form is to be completed by the provider and returned to the South Dakota Division of Medical Services.  
Only one provider can attest per form.

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Individual Provider Name: \_\_\_\_\_

Individual Provider NPI: \_\_\_\_\_

Billing NPI(s): \_\_\_\_\_

Did you attest for the PCP Enhanced Payment in 2013? *Check one:*                      Yes                      No

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**Physicians with at least 1 year of claims history:**

I attest that I am an eligible primary care specialist or sub-specialist in family practice, internal medicine, or pediatrics with board certification by the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS), or American Osteopathic Association (AOA).

*Check one:*                      ABMS                      ABPS                      AOA

I attest that I am an eligible primary care specialist or sub-specialist but I do not have a certification recognized by the AMBS, ABPS, or AOA. I attest that at least 60% of my total Medicaid claims submitted in the 12 months prior to the date of this attestation were for the E&M and vaccine administration codes allowed under federal law.\*

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**Physicians with between 1 and 12 months claims history:**

I attest that I am an eligible primary care specialist or sub-specialist in family practice, internal medicine, or pediatrics with board certification by the ABMS, ABPS or AOA.

*Check one:*                      ABMS                      ABPS                      AOA

I attest that I am an eligible primary care specialist or sub-specialist but I do not have a certification recognized by the AMBS, ABPS, or AOA. I attest that at least 60% of my total Medicaid claims submitted in the month prior to my signature on this form were for the E&M and vaccine administration codes allowed under federal law.\*

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**Advanced Practice Clinicians: Nurse Practitioners, Certified Nurse-Midwives, Physician Assistants**

I attest that I am an advanced practice clinician primary care practitioner and that my supervising physician has attested and is eligible to receive enhanced payments. The individual provider NPI of my supervising physician is: \_\_\_\_\_.

I declare under penalty of perjury under the laws of the state of South Dakota that the foregoing is true and correct.

\_\_\_\_\_  
Signature of Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print or type name of Provider

**South Dakota Medicaid prefers to receive completed forms via email.**

**Email, Fax, or Mail the completed form to:**

[EnhancedPCP@state.sd.us](mailto:EnhancedPCP@state.sd.us)

Fax: 605-773-5246

South Dakota Medicaid

700 Governor's Drive

Pierre, SD 57501

\* Evaluation and management codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474.

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*Internal Use Only:*    *Certification Verified:* \_\_\_\_\_    *Not Eligible:* \_\_\_\_\_    *Added to System:* \_\_\_\_\_