Annual Attestation for HIV Primary Care Providers
Assessment Year _____

HIV PCP Provider Name: _____ **Provider NPI:** _____

Clinic Site Name: _____

Practice Administrator Name: _____ **Phone:** _____

The identification of an HIV-qualified practitioner is based on both clinical experience and continuing education in HIV management, particularly in the area of antiretroviral therapy. VNS Health Select Health must ensure that HIV PCP/Specialists are qualified to join our network. The following criteria define an HIV PCP/Specialist:

1. Sees patients at least sixteen (16) hours per week over at least two (2) days at each primary care site.
2. Participates in a practice that provides 24 hour/7 day telephone coverage.
3. Completes ten (10) hours of HIV-related CME within the last twelve (12) months that includes information on the use of antiretroviral therapy in the ambulatory care setting.*
4. Has provided direct, ongoing care to at least twenty (20) HIV infected patients within the last twelve (12) months*

*Practitioners who have maintained a current HIV PCP/Specialist status by AAHIVM, meets the definition of an HIV-experienced provider by HIVMA or is credentialed as an ACRN by HANCB are eligible for designation as an HIV PCP/Specialist provided that they meet conditions 1 and 2 and provide a copy of their certification/recertification.

SECTION A: TO BE COMPLETED and SIGNED by the HIV PCP

1. Have you cared for at least twenty (20) HIV infected patients in the past twelve (12) months? ☐ Yes ☐ No

2. Have you completed ten (10) hours of HIV-related CME within the last twelve (12) months that includes information on the use of antiretroviral therapy in the ambulatory care setting? ☐ Yes ☐ No

3. If NO, do you meet the criteria of HIVMA, AAHIVM OR HANCB? ☐ Yes *(attach certificate)*
   ☐ No (Please explain how the criteria will be met by December 31 of this year)

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SECTION B: TO BE COMPLETED BY PRACTICE ADMINISTRATOR or HIV PCP

Instructions: Please specify the Hours of Availability (from – to time) for each site of care where the practitioner sees patients **as an HIV PCP** only.

Office 1 TIN:						
Office Name & Address:						
If <16 Hours, list covering providers						
MON	**TUE**	**WED**	**THU**	**FRI**	**SAT**	**SUN**
Covering Provider(s):						
Are you accepting new patients? ☐ Yes ☐ No						
Does the site have a provision for 24 hours/7 days per week coverage for urgent care matters? ☐ Yes ☐ No						
if No, please explain below:						

Office 2 TIN:						
Office Name & Address						
If <16 Hours, list covering providers						
MON	**TUE**	**WED**	**THU**	**FRI**	**SAT**	**SUN**
Covering Provider(s):						
Are you accepting new patients? ☐ Yes ☐ No						
Does the site have a provision for 24 hours/7 days per week coverage for urgent care matters? ☐ Yes ☐ No						
if No, please explain below:						

Office 1 TIN:						
Office Name & Address:						
If <16 Hours, list covering providers						
MON	**TUE**	**WED**	**THU**	**FRI**	**SAT**	**SUN**
Covering Provider(s):						
Are you accepting new patients? ☐ Yes ☐ No						
Does the site have a provision for 24 hours/7 days per week coverage for urgent care matters? ☐ Yes ☐ No						
if No, please explain below:						

Office 2 TIN:						
Office Name & Address						
If <16 Hours, list covering providers						
MON	**TUE**	**WED**	**THU**	**FRI**	**SAT**	**SUN**
Covering Provider(s):						
Are you accepting new patients? ☐ Yes ☐ No						
Does the site have a provision for 24 hours/7 days per week coverage for urgent care matters? ☐ Yes ☐ No						
if No, please explain below:						

Signature _____ **Date** _____

Please Email Completed form to:
Attention: VNS Health Select Health-HIV PCP
Email: Credentialing@vnshealth.org