



Department of Health and Human Services  
 MaineCare Services  
 Policy Division  
 11 State House Station  
 Augusta, Maine 04333-0011  
 Tel.: (207) 287-9368  
 TTY Users: Dial 711 (Maine Relay)

March 2015

Dear Provider,

MaineCare providers wishing to receive the primary care payment increase must fill out and submit the attached PCP Increase Self-Attestation form. Please note that hospitals, Federally Qualified Health Centers, and Rural Health Clinics are not eligible for the increase, so hospital-based physicians and physicians providing services with an FQHC or RHC pay-to should not attest. The increase will not occur until we have approved your form, but once approved, the increased payments will be retroactive to the date that this form was signed.

By completing the form, a provider attests that s/he is practicing with a specialty designation of (a) Family Medicine, (b) Internal Medicine, or (c) Pediatric Medicine.

Eligibility for the increase is limited to qualified physicians<sup>1</sup> and Advanced Practice Professionals (APPs)<sup>2</sup> practicing under their direct supervision.<sup>3</sup> The supervising physician must attest on behalf of any APPs they supervise and are responsible for (i.e., APPs should not attest themselves).

**Please return this form by mail or fax to:**

**Department of Health & Human Services, 11 SHS, 45 Commerce Dr., Augusta, 04333 Attn: Donna Sutter  
 FAX: (207) 430-3730, Attn: Donna Sutter**

Your provider file will be updated once we have approved your form, and we will send you a confirmation via email. If you have any questions, please contact Donna Sutter at (207) 629-4280.

Sincerely,

Stefanie Nadeau  
 Director, Office of MaineCare Services

Attachment: Self-Attestation Form  
 cc: Commissioner Mary C. Mayhew, Department of Health and Human Services

<sup>1</sup> Hospitals, Federally Qualified Health Centers, and Rural Health Clinics are not eligible for the increase.

<sup>2</sup> The following APPs are eligible for the increase:

Provider Type	Specialty
02-Advanced Practice Registered Nurse	014-Certified Clinical Nurse Specialist 015-Certified Nurse Midwife 016-Certified Nurse Practitioner
52-Physician Assistant	116-Physician Assistant

<sup>3</sup> Services provided by APPs do not need to be billed under the physician's billing number, but the attesting physician must have professional responsibility for the services provided.

**Self-Attestation for MaineCare Primary Care Rate Increase**

Beginning with Calendar Year 2015, eligible practitioners are those who practice in:

- Family Medicine
- Internal Medicine
- Pediatric Medicine

AS WELL AS

- Advanced Practice Registered Nurses or Physicians Assistants who bill under eligible practitioners and for whom eligible practitioners accept direct professional responsibility.

Physicians are individually responsible for submitting the self-attestation form, and under no circumstances shall someone other than the primary care physician submit the information required below. In addition, please note that Advanced Practice Professionals (Advanced Practice Registered Nurses, and Physicians Assistants) should not attest on their own behalf; rather the attesting physician who assumes professional responsibility for services provided by those practitioners should submit the form on their behalf.

Pay-To NPI:

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Physicians, please enter your Individual NPI:

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Physicians, please enter the NPI(s) of any Advanced Practice Professional you supervise and assume professional responsibility for, to allow these practitioners to receive the fee increase for eligible services:

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**1. I attest that I am practicing with a specialty designation of:**

Family Medicine

Internal Medicine

Pediatric Medicine

Please enter all three-digit MIHMS Service Location IDs where you qualify for the increased rate:

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I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. If I no longer meet the eligibility criteria in this form, or no longer wish to participate in this program, it is my obligation to notify the appropriate parties immediately. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

\_\_\_\_\_  
Signature of Qualifying Physician

\_\_\_\_\_  
Date

Contact Person if there are questions about this form: \_\_\_\_\_

Tel #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_