Molina Healthcare
Telemedicine Services Provider Attestation

Provider Name: _____

Molina Healthcare* (Molina) requires completion and return of this attestation for provision of all telehealth services.

You must meet all requirements below to deliver services to Molina members via telemedicine. Please review carefully to ensure your practice or organization meets each requirement. Completion and return of this attestation will designate you as a telemedicine provider for Molina and indicate you wish to provide services via telemedicine. In addition, all other requirements as described in the Molina Network Provider Agreement, Provider Handbook, and other policies and procedures are applicable to the provision of telemedicine services.

Telemedicine requirements ***Please check each box, as applicable, to indicate confirmation and understanding of requirement***
☐ Obtain member written consent specific to participation in telemedicine
☐ Have written protocols to ensure telemedicine services comply with the Health Insurance Portability and Accountability Act and meet the requirements of state and federal laws pertaining to patient privacy and established patient care standards
☐ Have written protocols to prevent fraud and abuse that address (a) authentication and authorization of users; (b) authentication of the origin of the information; (c) prevention of unauthorized access to the system or information; (d) system security, including the integrity of information that is collected, program integrity, and system integrity; and (e) maintenance of documentation about system and information usage
☐ Have written protocols for management of urgent/emergent situations
☐ Maintain a complete medical record of all telemedicine services provided to members and documentation of the telemedicine equipment used for the services provided
☐ Obtain a signed statement from the member or the member's authorized representative indicating their choice to receive services through telemedicine. The statement may be for a set period of treatment or a one-time visit, as applicable to the service(s) provided
☐ Practice must be covered by professional liability insurance for required limits per occurrence and aggregate through self, group or employer and include services performed via telemedicine in the coverage territory where the provision of services occurs
☐ Utilize secure and HIPAA compliant technology for all telehealth sessions. (**All telemedicine sessions must be conducted through secure and HIPAA-compliant technology. Note: FaceTime® is not considered secure, HIPAA-compliant technology.)**

[SIGNATURE PAGE TO FOLLOW]

I attest, by my signature, that my practice (individual, group, or organization) complies with all applicable Molina, state, and federal telehealth regulations and guidelines. I hereby certify that my representations contained in this document are true and accurate. I further understand that any information entered on this Attestation that subsequently is found to be false could result in termination of any agreement I may have or enter into with Molina and/or its affiliates.

I understand and agree that, as part of application process for delivery of telehealth services, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, and any other criteria used by Molina for determining initial and ongoing eligibility for participation. I acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

Provider Signature:	**Date:**

Provider's NPI: _____ **Provider's TIN:** _____

For group and organization providers:

Please complete the roster below for those direct services staff that provide telemedicine services.

****For large provider entities routinely submitting staff rosters to Molina, please provide this information on your roster submissions, via a telehealth indicator (in a unique column). Please attach to this form a roster of all telehealth practitioners. A current copy of the roster template may be found on molinahealthcare.com.**

Provider Name	NPI	Education	Professional Licensure	Service Address, City, State, Zip Code

Please return this completed form along with your staff roster to:

Email: MCCVA-Provider@molinahealthcare.com or
Fax: (888) 656-5098 or
Mail: 3829 Gaskins Road, Richmond, VA 23233
ATTN: Network Operations