Telehealth Provider Attestation

Provider Name: Provider Tax ID Number (TIN):

1. Are you able to provide telehealth services to WellCare/Staywell/CMS Health Plan members? If "Yes", please select all that apply below and complete items 2 – 8 *(note: affirmative answers are required for items 2 – 8 to continue providing telehealth services to members).*	Yes ☐ No ☐
• Primary Care Physician, Internist, or General/Family Practitioner	☐
• Behavioral Health Practitioner, Psychiatrist, or Community Mental Health Center	☐
• Physical Therapist, Occupational Therapist, or Speech Therapist	☐
• Endocrinologist	☐
• Nephrologist	☐
• Cardiologist	☐
• Gastroenterologist	☐
• Pulmonologist/Allergist	☐
• Rheumatologist	☐
• Hematologist	☐
• Other (please specify):	☐
2. Our equipment and processes for providing telehealth services are in compliance with the Health Insurance Portability and Accountability Act, HIPAA Guidelines, and other State and federal laws pertaining to patient privacy standards required by 45 CFR 164.312, and Rule 59G-1.057 F.A.C.	Yes ☐ No ☐
3. We use two-way, real time interactive communication between the patient and the provider.	Yes ☐ No ☐
4. We use audio and video interaction with patient.	Yes ☐ No ☐
5. We provide patients the choice of whether to access services through a face-to-face or telehealth visit with us.	Yes ☐ No ☐
6. We educate the patient, obtain consent, document the choice for telehealth in the patient's medical record, and include detailed notes from each visit.	Yes ☐ No ☐
7. We are responsible for all equipment required to provide telehealth services.	Yes ☐ No ☐
I attest that I represent the practice under "Provider Name" above. I further attest to the statements and answers above.	Yes ☐ No ☐

Printed Name: Title:

Phone Number:

Signature: Date:

Please return to:
FLTelehealth@wellcare.com

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