COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

REQUEST FOR MEDICAL ASSISTANCE ENROLLMENT ACTION

ACTION REQUESTED:

- **Add TELEHEALTH special indicator GT to enrollment record of an enrolled Medical Assistance rendering provider. The TELEHEALTH Provider must be enrolled in the MA Program before this action can be initiated.**

Individual rendering provider's NAME_____

13 digit PROMISe provider ID _____

National Provider Identifier (NPI)_____

Contact phone #_____

REQUESTED EFFECTIVE DATE _____

_____

Change authorized by DPW EXECUTIVE OFFICE:

_____ **(SIGNATURE)**

MATERNAL FETAL MEDICINE SPECIALIST TELEHEALTH INFORMATION REQUEST:

The following information is requested to enable the Department of Public Welfare to monitor telehealth program development, and not as a requirement to perform consultations using telecommunication technology.

1. Are you board certified in OB/GYN medicine?

YES___ NO____

2. a. Do you have a sub-specialty certification in Maternal Fetal Medicine?

YES___ NO___

b. Are you an active candidate (within 4 years of fellowship training) for a sub-specialty certification in Maternal Fetal Medicine?

YES___ NO___

3. a. Are you currently licensed in Pennsylvania?

YES___ NO___

b. If not licensed in Pennsylvania, list state of current medical license

_____

4. Are you currently enrolled in the MA Program?

YES___ NO___

5. a. Do you see patients in the state of Pennsylvania?

YES___ NO___

b. Do you see patients in states other than Pennsylvania?

YES___ NO___

6. Are you willing to be available for emergency consultations on a 24-hour basis, if requested?

YES___ NO

7. Check the methods that you will use to participate as a telehealth provider:

a. Telephone _____
b. Video conference technology _____

I affirm that the information submitted by me in this application is true and correct to the best of my knowledge and information

I hereby authorize the Department of Public Welfare to contact individuals or entities, including querying the National Practitioner Data Bank or the Healthcare and Integrity Protection Data Bank, for the purpose of verifying my credentials or the information contained in this application.

Signature _____

FOR USE BY OMAP ENROLLMENT:
CHANGE ENTERED BY:_____
DATE:_____