ATTACHMENT B

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

ATTESTATION FORM TO PROVIDE TELEHEALTH

Providers may use telehealth to provide behavioral health services based on their assurance to follow the OMHSAS Bulletin OMHSAS-20-02 as attested to by signature(s) to this document.

Instructions

Providers must complete Section I "Behavioral Health Provider Information" and Section II "Statement of Compliance and Signature" and submit the form to the electronic resource account RA-PWTBHS@pa.gov and to the appropriate OMHSAS Field Office at least 30 days prior to the anticipated start date of telehealth services.

I. Behavioral Health Provider Information

a. Provider type and license information *(check all applicable provider types and list license numbers below):*

Provider name:		
(Check)	**Provider Type**	**License number(s)**
	Psychiatric Outpatient Clinic	
	Partial Hospitalization Program	
	Drug & Alcohol Outpatient Clinic	
	Other (*specify below) (applicable only to HealthChoices network providers*)	

b. Contact person's name, phone number, and email address:

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
Office of Mental Health and Substance Abuse Services, Bureau of Policy, Planning & Program Development, P.O. Box 2675, Harrisburg, PA 17105. General Office Number 717-772-7900.

c. Originating site(s) and county(ies) served *(specify all originating site(s) and county(ies) served below, add rows as needed)*:

#	Originating Site Address	13-digit Provider PROMISe ID	County(ies) Served
1			
2			
3			
4			
5			

d. Name of BH-MCO(s) *(applicable only to BH-MCO Network Providers):*

e. List the procedure codes of services that will be provided using telehealth:
(*Please see OMHSAS Bulletin OMHSAS-20-02 Attachment A for a list of procedure codes for services that can be delivered using telehealth in FFS. BH-MCOs may allow additional services to be delivered using telehealth)*

II. Statement of Compliance and Signature:

(To be signed by the Authorized Representative of the Provider)

I understand behavioral health services using telehealth can be provided only after approval of this attestation form by OMHSAS. I also understand that telehealth programs are subject to monitoring reviews as determined by OMHSAS or BH-MCOs for the purpose of continuing authorization to utilize telehealth.

I hereby attest that telehealth services provided by _____
(*print name of the provider)*
will be in accordance with bulletin OMHSAS-20-02. All documentation required in this bulletin will be maintained and made available for review by the OMHSAS and/or BH-MCOs upon request.

Provider's Authorized Representative Name: _____

Provider's Authorized Representative Signature: _____ Date: _____

III. OMHSAS Approval

(To be completed by OMHSAS):

This Attestation has been reviewed for completeness. The provider is authorized to deliver services using telehealth based upon the assurances made by this attestation.

Please note that additional approval to provide services using telehealth may be required by BH-MCOs for providers in their network.

OMHSAS Representative Name: _____

OMHSAS Representative Signature: _____ Date: _____