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https://providers.amerigroup.com/TX

Attestation Form for Telemedicine and Telehealth Providers

I, the provider named below or the authorized representative thereof, hereby acknowledge and attest to comply with the following requirements:

1. Provider attests that my organization provides telemedicine health services and/or telehealth services to members.
2. Provider attests that if the member in receipt of these services (***recipient***) consents (or if appropriate, their parent or legal guardian consents) and has an assigned PCP or provider, notice is given to the recipient's PCP or provider regarding the telemedicine medical service or telehealth service rendered.
3. Provider attests that, for the purpose of sharing medical information, this notice includes exam findings, service summary, a list of prescribed or administered medications, and patient instructions.
4. Provider attests that records will be audited no less than annually to ensure that practitioners providing telemedicine and/or telehealth services underneath the TIN identified below meet the requirements outlined above.

Group/provider name:	
Provider type:	☐ Group ☐ Individual
TIN:	
NPI:	
Representative signature (stamped signature not accepted):	
Signing representative name:	
Title:	
Date:	

Please send completed forms to txproviderrelations@amerigroup.com.