ATTESTATION QUESTIONNAIRE

IDENTIFICATION AND NOTIFICATION OF HIV/AIDS SPECIALIST

☐ No, I do not wish to be designated as an HIV/AIDS specialist

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on criteria below:

- ☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine (AAHIVM); **or**
- ☐ I meet the criteria of the HIV Medicine Association (HIVMA) definition of an HIV-experienced physician; **or**
- ☐ I am a physician (MD or DO) who is providing the ongoing direct clinical ambulatory care of at least 20 HIV-infected persons who are being treated with antiretroviral therapy in the preceding 12 months.

I attest that, to the best of my knowledge, the above information is accurate and complete and can be supported by documentation (if required).

Date: _____

Physician's Name (print): _____

License #: _____

Physician's Signature: _____

Name of Group or Practice: _____

Telephone #: _____

Address: _____

Please fax the completed form to 518-386-7200.

If you have any questions, please contact
MVP's Credentialing Department at **1-888-363-9485.**

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