COMMONWEALTH of VIRGINIA
Virginia Department of Medical Assistance Services

Addiction and Recovery Treatment Services (ARTS)
Opioid Treatment Program (OTP) Attestation Form

Corporate Entity Legal Name: _____

NPI: _____ TIN# _____

Address: _____

Agency: _____

Network Organizational Credentialing Standards Attestation

DMAS ARTS program requirements follow the criteria defined by the American Society of Addictions Medicine (ASAM) for the provision of substance use disorder treatment services. ARTS providers shall have a current version of The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed., and provide services that meet these criteria. If your organization meets the a specific level of care based on the ASAM Criteria, and have trained and knowledgeable staff in applying the ASAM Criteria, you must complete and return this attestation to Magellan or a Medicaid health plan to be eligible for participation in the ARTS program. You must also complete and provide all additional credentialing and/or contracting documents required by Magellan or the Medicaid health plan you are enrolling with.

Providers must attach hereto an organization staff roster of only those individuals who attest to meet ASAM requirements for each specified level of care and attest only these staff shall treat DMAS-eligible members. By completing and submitting this form you attest that your agency meets the ASAM Level of Care requirements and that for each level of care specified herein the facility meets all of the support systems, staff, and therapies requirements as required in The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed..

Complete and submit the ARTS Opioid Treatment Program (OTP) Provider Attestation Form and any additional required credentialing and/or contracting documents to Magellan and the Medicaid health plans to start the credentialing process. Magellan and each Medicaid health plan will inform you if you meet their requirements to be enrolled or credentialed as a Medicaid provider in their network. Attesting to meeting ASAM Criteria does not guarantee enrollment or credentialing as a Medicaid provider.

I hereby certify that all information contained in this document is true and accurate. I further understand that any information entered in this document that subsequently is found to be false may result in termination of any agreement that I have or may enter into with DMAS and/or its contractors. I agree to maintain professional liability insurance coverage for direct care staff as referenced in this document and to update roster annually.

In compliance with the DMAS ARTS Provider Attestation Form, the Facility attests that it will permit only staff members who are fully licensed and/or meet DMAS program requirements established for Addiction Recovery and Treatment Services (ARTS) to see and treat Medicaid eligible members.

I hereby give permission and consent for DMAS and/or its contractors, to obtain and verify information provided in this form and consent to the release by any person, organization or other entity to DMAS and/or its contractors, of all information relevant to the evaluation of my ability to render addiction recovery and treatment services in a cost-effective manner and my moral and ethical qualifications, and agree to hold harmless any such person or organization from any cause of action based on the release of such information to DMAS and/or its contractors.

By signing this attestation I agree that all statements are true and agree to abide by any contracted requirements for the services delivered under the authority of this agreement.

Printed Name: _____

Title: _____

Signature: _____ **Date:** _____

CONTRACTED SITES OF CARE / Specific Service Delivery Location:

Please note: Sites of care cannot provide services to eligible members until credentialing and contracting is completed.

S1. MAIN SITE			
Legal Name of Provider:			
Program Name (if applicable):		Tax ID#:	
Street Address:		Medicare#:	
City/State/Zip Code:		Medicaid#:	
NPI(s)#		License#:	
Accreditation (if applicable):	☐ AAAHC ☐HFAP ☐CARF ☐ COA ☐ TJC	License Type:	
Site Treatment Setting (Check one)	☐General Hospital ☐Freestanding Psychiatric Hospital ☐Physician Office ☐Psychiatry clinic ☐CSB ☐Outpatient health system clinic ☐FQHC ☐Health Department ☐Primary care clinic ☐Other:		

S2			
Legal Name of Provider:			
Program Name (if applicable):		Tax ID#:	
Street Address:		Medicare#:	
City/State/Zip Code:		Medicaid#:	
NPI(s)#		License#:	
Accreditation (if applicable):	☐ AAAHC ☐HFAP ☐CARF ☐ COA ☐ TJC	License Type:	
Site Treatment Setting (Check one)	☐General Hospital ☐Freestanding Psychiatric Hospital ☐Physician Office ☐Psychiatry clinic ☐CSB ☐Outpatient health system clinic ☐FQHC ☐Health Department ☐Primary care clinic ☐Other:		

S3			
Legal Name of Provider:			
Program Name (if applicable):		Tax ID#:	
Street Address:		Medicare#:	
City/State/Zip Code:		Medicaid#:	
NPI(s)#		License#:	
Accreditation (if applicable):	☐ AAAHC ☐HFAP ☐CARF ☐ COA ☐ TJC	License Type:	
Site Treatment Setting (Check one)	☐General Hospital ☐Freestanding Psychiatric Hospital ☐Physician Office ☐Psychiatry clinic ☐CSB ☐Outpatient health system clinic ☐FQHC ☐Health Department ☐Primary care clinic ☐Other:		

CONTRACTED SITES OF CARE / Specific Service Delivery Location:

Please note: Sites of care cannot provide services to eligible members until credentialing and contracting is completed.

S4			
Legal Name of Provider:			
Program Name (if applicable):		Tax ID#:	
Street Address:		Medicare#:	
City/State/Zip Code:		Medicaid#:	
NPI(s)#		License#:	
Accreditation (if applicable):	☐ AAAHC ☐HFAP ☐CARF ☐ COA ☐ TJC	License Type:	
Site Treatment Setting (Check one)	☐General Hospital ☐Freestanding Psychiatric Hospital ☐Physician Office ☐Psychiatry clinic ☐CSB ☐Outpatient health system clinic ☐FQHC ☐Health Department ☐Primary care clinic ☐Other:		

S5			
Legal Name of Provider:			
Program Name (if applicable):		Tax ID#:	
Street Address:		Medicare#:	
City/State/Zip Code:		Medicaid#:	
NPI(s)#		License#:	
Accreditation (if applicable):	☐ AAAHC ☐HFAP ☐CARF ☐ COA ☐ TJC	License Type:	
Site Treatment Setting (Check one)	☐General Hospital ☐Freestanding Psychiatric Hospital ☐Physician Office ☐Psychiatry clinic ☐CSB ☐Outpatient health system clinic ☐FQHC ☐Health Department ☐Primary care clinic ☐Other:		

S6			
Legal Name of Provider:			
Program Name (if applicable):		Tax ID#:	
Street Address:		Medicare#:	
City/State/Zip Code:		Medicaid#:	
NPI(s)#		License#:	
Accreditation (if applicable):	☐ AAAHC ☐HFAP ☐CARF ☐ COA ☐ TJC	License Type:	
Site Treatment Setting (Check one)	☐General Hospital ☐Freestanding Psychiatric Hospital ☐Physician Office ☐Psychiatry clinic ☐CSB ☐Outpatient health system clinic ☐FQHC ☐Health Department ☐Primary care clinic ☐Other:		