EXHIBIT J

TELEMEDICINE SERVICES PROVIDER ATTESTATION
TO
MAGELLAN HEALTHCARE, INC.
NETWORK PROVIDER AGREEMENT

Provider Name: RecipientName
MIS: RecipientGSProviderID

Florida defines telemedicine as the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment (59G-1.057, F.A.C.).

Magellan Complete Care* (Magellan) requires the completion and return of this attestation for provision of all telemedicine services in order to comply with the Model Health Plan Contract between Magellan and Agency for Health care Administration (AHCA (Contract).

You must meet all requirements below to deliver services to Magellan members via telemedicine. Please review carefully to ensure your practice or organization meets each requirement. Completion and return of this attestation will designate you as a telemedicine provider for Magellan and indicate you wish to provide services via telemedicine. In addition, all other requirements as described in the Magellan Provider Agreement, Provider Handbook, and other policies and procedures are applicable to the provision of telemedicine services.

Telemedicine requirements ***Please check each box, as applicable, to indicate confirmation and understanding of requirement***
☐ Obtain member written consent specific to participation in telemedicine
☐ The telecommunication equipment and telemedicine operations meet the technical safeguard required by 45 CFR 164.312, where applicable
☐ Have written protocols to ensure telemedicine services comply with the Health Insurance Portability and Accountability Act and meet the requirements of state and federal laws pertaining to patient privacy and established patient care standards
☐ Have written protocols to prevent fraud and abuse that address (a) authentication and authorization of users; (b) authentication of the origin of the information; (c) the prevention of unauthorized access to the system or information; (d) system security, including the integrity of information that is collected, program integrity, and system integrity; and (e) maintenance of documentation about system and information usage.
☐ Participate in Magellan training regarding telemedicine requirements of the Contract.
☐ Have written protocols for management of urgent/emergent situations
☐ Maintain a complete medical record of all telemedicine services provided to members and documentation of the telemedicine equipment used for the services provided
☐ Obtain a signed statement from the member or the member's authorized representative indicating their choice to receive services through telemedicine. The statement may be for a set period of treatment or a one-time visit, as applicable to the service(s) provided.
☐ Practice must be covered by professional liability insurance for required limits per occurrence and aggregate through self, group or employer and include services performed via telemedicine in the coverage territory where the provision of services occurs
Identify what secure technology you currently use (**All telemedicine sessions must be conducted through secure and HIPAA compliant technology. Note: FaceTime® is not considered secure, HIPAA compliant technology)**: ☐ American Well ☐ SecureTelemedicine.com ☐ SecureVideo.com ☐ e-Psychiatry ☐ Other (Please list website address): ____________________

[SIGNATURE PAGE TO FOLLOW]

I attest, by my signature, that my practice (individual, group, or organization) meets all the criteria above. I have also read the Magellan Provider Handbook and other supplemental materials and understand requirements for delivery of services, including telemedicine services, for Magellan. I understand that it is my responsibility to comply with all Magellan, state, and federal telemedicine regulations and guidelines. I hereby certify that my representations contained in this document are true and accurate. I further understand that any information entered on this Attestation that subsequently is found to be false could result in termination of any agreement I may have or enter into with Magellan and/or its affiliates.

I understand and agree that, as part of application process for delivery of telemedicine services, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, and any other criteria used by Magellan for determining initial and ongoing eligibility for participation. I acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

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Provider Signature **Date**

____

Provider Printed Name

____

Provider's NPI **Provider's TIN**

Please list the state(s) for which you are licensed:

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For group and organization providers:
Please complete the roster below for those direct services staff that provides telemedicine services. Additional pages may be added for additional staff.

Provider Name	NPI	Degree/ Education	Professional Licensure	Service Address	City, State, Zip Code

Please return this completed form to:
Fax: #1-888-656-3804 or
Mail: 14100 Magellan Plaza, Maryland Heights, MO 63043-4644, Attention: Network Operations

*Florida MHS, Inc. d/b/a Magellan Complete Care, and its respective affiliates and subsidiaries are affiliates of Magellan Health, Inc. (collectively "Magellan").