Verification of Qualifications *for* HIV/AIDS PHYSICIAN SPECIALIST

Health plans and healthcare organizations must implement regulations related to AB2168 (Ch. 426, 2000). This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS-34-01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

Please check <u>ANY and ALL</u> of the criteria listed below that apply to you.

☐ 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 the below criteria:

☐ I am credentialed as a "HIV Specialist" by the American Academy of HIV Medicine (attached AAHIVM Certification);

OR

☐ I am Board Certified in Infectious Disease **AND** in the preceding **twelve (12)** months have clinically managed a minimum of **twenty-five (25)** HIV patients **and** have successfully completed **fifteen (15)** hours of category 1 continuing medical education (CME) in HIV medicine, **five (5)** hours of which was related to antiretroviral therapy;

OR

☐ In the past **twenty-four (24)** months, I have provided clinical management of **twenty (20)** patients; **and** in the past **twelve (12)** months completed board certification in Infectious Disease

OR

☐ In the past **twenty-four (24)** months I have provided clinical management to **twenty (20)** HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV Medicine;

OR

☐ In the past **twenty-four (24)** months I have clinically managed at least 20 HIV patients and in the past **twelve (12)** months have completed 15 hours of category of 1 CME in HIV Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine (attach copies of the CME credits and Exam verification)

I attest that, to the best of my knowledge, the above information can be supported by documentation, (*see attached).*

Name of Practitioner (Please print): _____ Date: _____

Practitioner's Signature: _____ License No: _____

Office Telephone _____ Office Fax: _____

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