COMMONWEALTH of VIRGINIA
Virginia Department of Medical Assistance Services

Addiction and Recovery Treatment Services (ARTS) Provider Attestation Form
ASAM Levels 2.1 to 4.0

Corporate Entity Legal Name: _____

NPI: _____ TIN# _____

Address: _____

Agency: _____

Phone Number: _____

Network Organizational Credentialing Standards Attestation

DMAS ARTS benefit requirements follow the criteria defined by the American Society of Addiction 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.

Providers must attach hereto the ARTS Organizational 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 Medicaid 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. **You are attesting that your staff members are performing the following: educating members on Medication Assisted Treatment (MAT) as the standard of care, performing assessments that specifically address MAT with specific recommendations for treatment and documenting how members will receive access to MAT for both withdrawal management and maintenance, including coordination of access when clinically indicated.**

Your organization must be licensed through Virginia Department of Behavioral Health & Developmental Services (DBHDS) to meet the specific level of care based on the ASAM Criteria, and have trained and knowledgeable staff in applying the ASAM Criteria. Providers must complete and submit this ARTS Provider Attestation Form, ARTS Organizational Staff Roster, copy of the DBHDS ASAM license and any additional required credentialing and/or contracting documents to each Medicaid Managed Care Organization (MCO) and Magellan of Virginia to start the credentialing process.

Providers applying for a DBHDS license may email these forms to SUD@dmas.virginia.gov with the subject heading "Substance Use Provider Application Expedite Review Request" DMAS may coordinate an expedited review with DBHDS based on service needs in your specific area.

Please submit forms to Medicaid MCOs and Magellan of Virginia and they 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:** _____

Program Type Treatment Setting	ASAM LOC	Site of Care Codes (List S1, S2, etc.)	Population (Check all that apply)
Medically Managed Intensive Inpatient Services VDH Licensed Acute Care Hospitals – **No attestation required.** **New:** DBHDS Licensed SA Intensive Inpatient – **Attestation required**	**4.0**		☐Adults ☐Adolescents/Children
Medically Monitored High-Intensity Inpatient Services DBHDS Licensed: SA Intensive Inpatient	**3.7**		☐Adults ☐Adolescents/Children
Clinically Managed High-Intensity Residential Services DBHDS Licensed: SA Clinically managed, Medium-Intensity Residential	**3.5**		☐Adults ☐Adolescents/Children
Clinically Managed Population-Specific High-Intensity Residential Services DBHDS Licensed: SA Specific High-Intensity Residential	**3.3**		☐ Adults Only, population specific
Clinically Managed Low-Intensity Residential Services DBHDS Licensed: Clinically Managed Low-Intensity Residential Care for Adults DBHDS License: SA Clinically managed low-intensive residential	**3.1**		☐Adults ☐Adolescents/Children
Partial Hospitalization Services DBHDS licensed: SA Partial Hospitalization	**2.5**		☐Adults ☐Adolescents/Children
Intensive Outpatient Services DBHDS licensed: SA Intensive Outpatient	**2.1**		☐Adults ☐Adolescents/Children

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/FIPS:		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/FIPS:		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/FIPS:		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:		

S4			
Legal Name of Provider:			
Program Name (if applicable):		Tax ID#:	
Street Address:		Medicare#:	
City/State/Zip/FIPS:		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/FIPS:		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/FIPS:		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:		

S7			
Legal Name of Provider:			
Program Name (if applicable):		Tax ID#:	
Street Address:		Medicare#:	
City/State/Zip/FIPS:		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:		