COMMONWEALTH of VIRGINIA
Virginia Department of Medical Assistance Services

Addiction and Recovery Treatment Services (ARTS) Provider Attestation Form

ASAM Levels 2.1 to 3.7

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.

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.

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 this ARTS Provider Attestation Form, ARTS Organizational Staff Roster and any additional required credentialing and/or contracting documents and submit to Magellan and each Medicaid health plans you are enrolling with to start the credentialing process. **Providers attesting to meet the ASAM Levels 3.1, 3.3, 3.5, or 3.7 are also required to submit this ARTS Provider Attestation Form, ARTS Organizational Staff Roster, and a copy of the provider's DBHDS license to the DMAS contact listed on next page.**

Providers applying for a DBHDS license or modifying an existing DBHDS license should email these forms to SUD@dmas.virginia.gov with the subject heading "Substance Use Provider Application Expedite Review Request" so that DMAS may coordinate an expedited review with DBHDS.

Magellan and the Medicaid health plans 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 Crosswalk	Site of Care Codes (List S1, S2, etc.)	Population (Check all that apply)
***Medically Monitored Intensive Inpatient Services (Adult)** **High Intensity Inpatient (Adolescents)** Department of Behavioral Health and Developmental Services (DBHDS) Licensed: • Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License; • Substance Abuse Residential Treatment Services (RTS) for adults/children with a DBHDS Managed Withdrawal License; • Residential Crisis Stabilization Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License; • Substance Abuse Residential Treatment Services (RTS) for Women with Children with a DBHDS Managed Withdrawal License; • Level C or Mental Health Residential Children with a substance abuse residential license and a DBHDS Managed Withdrawal License; • Managed Withdrawal-Medical Detox Adult Residential Treatment Service (RTS) License; or • Medical Detox/Chemical Dependency Unit for Adults.	**3.7**		☐Adults ☐Adolescents/Children
***Clinically Managed High Intensity Residential Services (Adults)** **Medium Intensity (Adolescents)** DBHDS Licensed: • Substance Abuse Residential Treatment Services (RTS) for Adults or Children; • Psychiatric Unit that have substance abuse on their license or within the "licensed as statements"; • Substance Abuse RTS for Women with Children; • Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the "licensed as statements."; or • Level C or Mental Health Residential Children that have substance abuse on their license or within the "licensed as statements". • If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detox license.	**3.5**		☐Adults ☐Adolescents/Children
***Clinically Managed Population Specific High Intensity Residential Services (Adult Only)** DBHDS Licensed: • Substance Abuse Residential Treatment Services (RTS) for Adults; • Substance Abuse Residential Treatment Services (RTS) for Women with Children; • Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the "licensed as statements." or • Level C or Mental Health Residential Children that have substance abuse on their license or within the "licensed as statements." • If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detox license.	**3.3**		☐ Adults, population specific
***Clinically Managed Population Low Intensity Residential Services** DBHDS Licensed: • Mental Health and Substance Abuse Group Home Service for Adults and Children (Required for co-occurring enhanced programs) • Supervised Residential Treatment Service (RTS) for Adults	**3.1**		☐Adults ☐Adolescents/Children
Day Treatment/Partial Hospitalization • DBHDS licensed Substance Abuse or Substance Abuse/Mental Health Partial Hospitalization	**2.5**		☐Adults ☐Adolescents/Children
Intensive Outpatient Services • DBHDS licensed Substance Abuse Intensive Outpatient for Adults, Children and Adolescents	**2.1**		☐Adults ☐Adolescents/Children

***Providers attesting to Residential ASAM Levels 3.1, 3.3, 3.5 and 3.7 are required to submit** the ARTS Attestation Form, DBHDS license and ARTS Organizational Staff Roster to DMAS via email (to expedite the review) and also mail in signed copy. *Please include name of primary contact, email, and phone for contractor to coordinate the review.*

Name: _____ Email: _____ Telephone: _____

Indicate MCO Region(s) served: _____

ARTS Managed Care Regions: http://www.dmas.virginia.gov/Content_atchs/mc/gmap14.gif

Email: SUD@dmas.virginia.gov

Mail signed copy: DMAS / Addiction and Recovery Treatment Services (ARTS)
Attention: Ashley Harrell
600 East Broad Street, Suite 1300, Richmond, Virginia 23219

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:		

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.

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:		

S8			
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:		