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AUTISM EVALUATION PRACTITIONER (AEP)
Attestation

Name of Practitioner ______________________________
Practitioner NPI ______________________________
Practitioner Medicaid Provider Number______________
Name of Agency______________________________ **Agency NPI**___
Agency Medicaid Provider Number ______________________________

Contracted with:

- ☐ Blue Cross/Blue Shield of New Mexico
- ☐ Presbyterian Health Plan
- ☐ Western Sky Community Care
- ☐ Not yet enrolled

I, INSERT PRACTITIONER'S NAME, hereby attest that I meet the standards as set forth in the New Mexico Administrative Code (NMAC) rules and any subsequent supplements or policy and billing manuals to render Applied Behavior Analysis (ABA) Stage 1 Services as an approved Medical Assistance Division (MAD) Autism Evaluation Practitioner (AEP).

I. I am a licensed (check one)

- ☐ Doctoral level clinical psychologist
- ☐ MD/DO board certified or board eligible
  - In developmental behavioral pediatric neurology
  - Pediatric Neurology
  - Child Psychiatry
  - Adolescent Psychiatry
  - Adult Psychiatry

Additionally, I meet all the following (A-E) requirements.

A. I have experience in or knowledge of the medically necessary use of ABA and other empirically supported intervention techniques.

B. I am qualified to conduct and document a Medical Assistance Division (MAD) Comprehensive Diagnostic Evaluation (CDE), a Targeted Evaluation and a Risk Evaluation for the purposes of determining if the recipient meets the criteria for a diagnosis of Autism Spectrum Disorders (ASD) or meets the MAD At-Risk Criteria for ASD diagnosis and complete an Integrated Service Plan (ISP), a Risk Report, and ISP updates.

C. I have advanced training and clinical experience in the diagnosis and treatment of ASD and related neurodevelopment disorders, including knowledge about typical and atypical child, adolescent or when rendering services to a recipient over 20 years of age, adult development, and experience with variability within the ASD population.

D. I have advanced training in differential diagnosis of ASD from other developmental, psychiatric, and medical disorders.

E. I further attest that all provider criteria, as outlined in applicable NMAC rules, supplements, and policy and billing manuals are met and will continue to be met. When requested, I will provide documentation substantiating training, experience, and licensure to MAD.

II. I have attached my current New Mexico practice board's license. I will maintain my licensure throughout the time I render ABA Stage 1 services and provide MAD's fiscal agency with license renewals prior to the expiration of my current one. I will report any change in my licensure status in-between renewals immediately to the MAD ABA Staff Manager and each Human Services Department (HSD) contracted managed care organizations (MCOs).

Print Name and Title, Date and Sign

AGENCY

If you are the sole owner of the agency, sign for yourself. If you co-own the agency, request one of the other owners to complete. If you work for an agency, please have someone such as the agency's HR sign.

I, INSERT NAME of AGENCY OFFICIAL, hereby attest that INSERT PRACTITIONER'S NAME has presented documentation to substantiate their education and experience requirements as listed above and a copy of their current New Mexico license as a ______________________________. The agency has placed a copy of the required education and experience as detailed above in their personnel file and will add all subsequent licensure renewals.

Print Name and Title, Date and Sign