NEW YORK STATE OF OPPORTUNITY. Department of Health

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Governor

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Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

Medicaid Hepatitis C Practitioner Information Request Form

Prescriber Information		
PRESCRIBER NAME:		
10-DIGIT NPI NUMBER:	**OFFICE PHONE NUMBER:** ( ) -	**OFFICE FAX NUMBER:** ( ) -
ADDRESS:		
EMAIL:		
ARE YOU A GASTROENTEROLOGIST, HEPATOLOGIST, TRANSPLANT PHYSICIAN OR INFECTIOUS DISEASE SPECIALIST? ☐ **YES** ☐ **NO** **IF YES, PLEASE PROVIDE SPECIALTY:**		
IF NO, DO YOU HAVE CLINICAL EXPERIENCE WITH THE MANAGEMENT AND TREATMENT OF HEPATITIS C VIRUS (HCV) INFECTION? ☐ **YES** ☐ **NO** ***Clinical experience is defined as the management AND treatment of at least 10 patients with HCV infection within the past 12 months and at least 10 HCV- related CME credits in the last 12 months.*** **ARE YOU WORKING IN COLLABORATION WITH A SPECIALIST/EXPERIENCED HCV PRESCRIBER WHO MEETS THE ABOVE CLINCIAL EXPEREINCE CRITERIA** ☐ **YES** ☐ **NO** **PROVIDE NAME OF COLLABORATING SPECIALIST/EXPERIENCED HCV PRESCRIBER:** **AND** **DO YOU HAVE AT LEAST 10 HCV-RELATED CME CREDITS IN THE LAST 12 MONTHS?** ☐ **YES** ☐ **NO**		

I attest that all of the information on this form is accurate. I attest that documentation of the above is available for review if requested by New York Medicaid.

PRESCRIBER'S SIGNATURE **DATE**

Once complete please email form to ppno@health.ny.gov or fax to 518-473-5508