IMPORTANT!
RESPONSE REQUIRED!

Deadline: Wednesday, June 30, 2021

On an annual basis, Inland Empire Health Plan (IEHP) is required to survey their Providers to find out which Providers would like to be listed as HIV/AIDS Specialist.

Please review, complete, sign and date the attached
HIV/AIDS Specialist Survey
by Wednesday, June 30, 2021.

All "Yes" responses require supporting documentation to confirm HIV/AIDS Specialist criteria is met.

Please provide your responses to IEHP's Credentialing Dept.
via email at credentialing@iehp.org or via fax (909) 890-5756

Your prompt attention will greatly be appreciated.

INLAND EMPIRE HEALTH PLAN
10801 6th Street, Suite #120, Rancho Cucamonga, CA 91730
Tel: (909) 890-2054 Fax: (909) 890-5756 email: credentialing@iehp.org

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, if required.

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

Provider's Signature: _____ License No: _____

Office Telephone _____ Office Fax: _____

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