IMPORTANT!
RESPONSE REQUIRED!

Deadline: Wednesday, July 15, 2020

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

Please review, complete, sign and date the attached HIV/AIDS Specialist Survey.

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 credentialing@iehp.org or via fax (909) 890-5756

Your prompt attention will greatly be appreciated.
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 ANY and ALL 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 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 Practitioner
(Please print): ________________________________ Date: __________________
Practitioner’s Signature: ________________________________ License No: __________________
Office Telephone: ________________________________ Office Fax: ________________