Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-6806-ENG 1-24

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Telehealth Provider Assurance Statement

You are required to complete all of the information requested on this form.

PROVIDER TYPE	PROVIDER NAME		
REQUESTED SERVICE EFFECTIVE DATE	NPI or UMPI		
PRACTICE ADDRESS	CITY	STATE	ZIP CODE

This assurance statement is an addendum to the provider's Minnesota Health Care Programs (MHCP)) Fee-for-Service (FFS) only or FFS and Managed Care Organization In-Network Provider Agreement (DHS-4138) (PDF) or Managed Care Organization In-Network Provider Agreement (DHS-8355) (PDF).

Telehealth Definition

Telehealth is the delivery of health care services or consultations through electronic communication while the patient is at one site and the qualified health care provider is at a distant site. MHCP covers medically necessary services and consultation by select health care providers through telehealth in the same manner as if the service or consultation was delivered in person. Minnesota Statutes, 254B.05, subdivision 5(f) and 256B.0625, subdivision 3b, as applicable.

Refer to the Early Intensive Developmental and Behavioral Intervention (EIDBI) telehealth services, the Telehealth Delivery of Substance Use Disorder Services, the Telehealth Delivery of Mental Health Services, Physician and Professional Services or Telehealth Services MHCP provider manual sections for more information about providing services via telehealth.

Provider Assurance Statement

Individual providers: Initial each requirement. Print your name and sign this assurance statement.

Organizational providers: An administrator, manager, director or authorized representative must initial each requirement, print the name of the person signing, and sign this assurance statement.

By initialing each requirement (electronic initials accepted) and signing this form, I, the provider named on this form, agree to comply with the following requirements and maintain documentation of this compliance:

Provider's initials required. Do not use an X or checkmark.

_____ Have written policies and procedures specific to telehealth services that I review and update regularly.

_____ Have policies and procedures that adequately address patient safety before, during and after the telehealth service is rendered.

_____ Have established protocols addressing how and when to discontinue telehealth services.

_____ Have an established quality assurance process related to telehealth services which includes all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements.

_____ Have documentation of each occurrence of a health care service provided by telehealth that includes all of the following:

- The type of service provided
- The time the service began and the time the service ended, with a.m. and p.m. designations
- A description of the provider's basis for determining that telehealth is an appropriate and effective means for delivering service to the member
- The mode of transmission of the telehealth service
- The location of the originating and the distant site

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes, 325L.02(h), 325L.05 and 325L.08)

PROVIDER NAME (authorized representative)	PROVIDER SIGNATURE	DATE

CONTACT NAME	PHONE NUMBER (include area code)	EXTENSION

Telehealth services are granted to eligible providers enrolled with MHCP.

Upload this signed Telehealth Provider Assurance Statement through the Minnesota Provider Screening and Enrollment (MPSE) portal or fax to 651-431-7462. Include your completed MHCP provider enrollment application packet and other required documents if you are not enrolled with MHCP. Keep signed copies for your records.