



Telemedicine Program Provider Addendum

Originating Site Provider Information

Organization Name:

NPI:

MA #:

Tax ID#:

Name of Primary Contact Person:

Title of Primary Contact Person:

Primary Address:

City:

State:

Zip Code:

Phone:

Fax:

Email:

Provider Type (check all that apply):

Physician (please specify type)

Nurse Practitioner

Nurse Midwife

Facility Type (check one):

FQHC

Local Health Department

Hospital, including emergency department

Nursing Facility

Renal Dialysis Center

Private Office

Originating Site

Signature: _____

Date: _____

Print Name and Title: _____

Distant site provider information follows on page 2.

Distant Site Provider Information

Organization Name:

NPI:

MA #:

Tax ID#:

Name of Primary Contact Person:

Title of Primary Contact Person:

Primary Address:

City:

State:

Zip Code:

Phone:

Fax:

Email:

Provider Type (check all that apply):

Physician (please specify type)

Nurse Practitioner

Nurse Midwife

Facility Type (check one):

FQHC

Local Health Department

Hospital, including emergency department

Nursing Facility

Renal Dialysis Center

Private Office

Distant Site

Signature: _____

Date: _____

Print Name and Title: _____

Please attach a copy of the contract or agreement between the Originating Site and the Distant Site provider, including billing-related responsibilities for each provider.

Telemedicine service delivery plan details follow on page 3.

Telemedicine Service Delivery Plan

Please provide and attach information for the following areas.

1. How many individuals do you expect to serve through telemedicine?
2. Describe services to be provided.
3. Describe protocol for determining medical necessity for Originating Site providers.
4. Describe protocol for confidentiality.
5. Describe procedures for maintenance of telemedicine documentation in the individual's medical record at both the Originating Site and Distant Site.
6. Describe pharmacy protocol, as it relates to telemedicine.
7. Describe the quality monitoring system for telemedicine care.
8. Describe technology you will use to perform telemedicine services. Please provide the names of specific technology or software.
9. Provide a written contingency plan for when telemedicine is unavailable.
10. Please provide any additional information you think would be helpful.
11. Please attest that all participating originating and distant sites have, at a minimum, video technology components as follows:
 - A camera that has the ability to manually or under remote control provide multiple view of a patient with the capability of altering the resolution, focus, and zoom requirements according to the consultation;
 - Display monitor size sufficient to support diagnostic needs used in the telemedicine service;
 - Audio equipment that ensures clear communication and includes echo cancellation;
 - Bandwidth speeds sufficient to provide quality video to meet or exceed 15 frames per second; and
 - Creates video and audio transmission with less than 300 milliseconds.

I attest that all participating sites meet the minimum technology requirements listed above and will continue to meet the requirements as long as telemedicine services are being provided.

Addendum submission information is on the following page.

Provider addendum may be submitted for review via email, fax, or mail.

Email: dhmh.telemedicineinfo@maryland.gov

Mail: Medicaid Office of Health Services
Department of Health & Mental Hygiene
201 West Preston Street, Room 118
Baltimore, MD 21201

Fax: 410-333-5154

For DHMH use only

Internal Checklist

Originating site:

Distant site:

NPI:

NPI:

MA #:

MA #:

Reviewer:

Approved / Denied:

Date:

Notification date regarding application status:

If applicable, date of PIS for COS change to PT 57 or 61: