IMPORTANT!
RESPONSE REQUIRED!

Deadline: Thursday June 30th, 2022

On an annual basis, Inland Empire Health Plan (IEHP) is required to survey their 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
by Thursday, June 30th, 2022

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.

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 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 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, (Please attach).

Name of Practitioner (Please print): ______________________ Date: ______________

Practitioner's Signature: ______________________ License No: ______________

Office Telephone ______________________ Office Fax: ______________