RESET

OBAT and Navigator Attestation for Nonparticipating Providers

NJ licensed physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Advance Practice Nurses (APNs), Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthetists (CRNAs) and Certified Nurse Midwives (CNMs) that provide Office Based Addiction Treatment (OBAT) to patients enrolled in Horizon NJ Health plans must complete this form to attest that they, both the practitioner and the practice, meet all requirements and comply with all guidelines established by the NJ Division of Medical Assistance and Health Services and the Division of Mental Health and Addiction Services in regard to providing OBAT to our members with an addiction diagnosis.

Horizon will use the information provided to update our systems to reflect that your compliance with the guidelines noted above.

This completed and signed form may be emailed, along with a copy of your W-9, to EnterprisePDM@Horizonblue.com.

REQUESTOR INFORMATION

Requestor Name _____

Requestor Phone Number _____

Requestor Email address _____

Date of Request _____

PRACTITIONER INFORMATION

Practitioner Name _____

Practitioner Specialty _____

Practitioner Type 1 NPI _____

Practitioner Social Security Number _____

Practitioner Medical License Number _____

Practitioner DEA Number _____

☐ I attest that the above-named physician/physician extender is DATA 2000 waivered for prescribing buprenorphine as part of an OBAT program.

(Continues)

PRACTICE INFORMATION

Practice Name _____

Practice Type 2 NPI _____

Practice Tax Identification Number (TIN) _____

Practice Primary Specialty _____

Practice Address _____

Practice City State ZIP _____

Practice Telephone Number _____

Practice Fax Number _____

BILLING INFORMATION *(from where we receive claims)*

Billing NPI type 2 Number _____

Billing Address _____

Billing City, State Zip _____

Billing County _____

Billing Telephone Number _____

Billing Fax Number _____

REMITTANCE INFORMATION *(where we are to send payments)*

Remittance Address _____

Remittance City, State ZIP _____

Remittance County _____

Remittance Telephone Number _____

Remittance Fax Number _____

NAVIGATOR ATTESTATION

If your practice provides Office Based Addictions Treatment (OBAT) services to patients enrolled in Horizon NJ Health plans please review the following information and select the appropriate box below about your use of Navigators.

A Navigator in an Office-Based Addiction Treatment (OBAT) practice can be: a licensed healthcare provider acting within his or her scope of practice under state law; an individual with a baccalaureate degree and at least two years of lived experience; or an individual with an associate's degree or certified medical assistant and four years of lived experience. Navigators utilize experiential knowledge, skills and coaching to guide and assist beneficiaries to obtain, and maintain, services designed to assist them maintain recovery.

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NAVIGATOR ATTESTATION *(continued)*

"Lived experience" is defined as having knowledge of substance use disorders or mental illness gained through direct, personal experience through one's own successful recovery process as well as individuals who have gained direct experience with successful treatment of substance use disorder and/or mental illness through either a personal relationship or professional contact with individuals suffering from substance use disorder or mental illness.

Please note when providing Office Based Addiction Treatment (OBAT) to a particular patient with an addiction diagnosis, an individual provider cannot serve as *both* Navigator and Prescriber.

As part of an OBAT program, practices MUST employ Navigators.

As a representative authorized to speak on behalf of the practice, I attest that:

☐ No, the practice does not employ Navigators.

Please note that if your practice does not employ Navigators, we cannot reimburse you for OBAT services provided to our patients.

☐ Yes, the practice employs Navigators.

If you answered "Yes" above, you **must** provide the date on which your practice began employing Navigators.

The practice began employing Navigators on date (mm/dd/yyyy) _____ and has continued to employ Navigators, without a break, to the present time.

Please also provide the following information about the Navigators in your practice. Include a separate sheet as necessary.

Navigator (1) Name _____

Navigator (1) Specialty _____

Navigator (1) Type 1 NPI _____

Navigator (2) Name: _____

Navigator (2) Specialty _____

Navigator (2) Type 1 NPI _____

Navigator (3) Name: _____

Navigator (3) Specialty _____

Navigator (3) Type 1 NPI _____

REQUESTOR ATTESTATION

As a representative authorized to speak on behalf of the practice, I attest that the information provided on this form is accurate and complete.

Practitioner Signature _____

Date _____

Please note that completion and submission of this information does not change your nonparticipation status with Horizon NJ Health plans/products, nor should this information be viewed as a request to participate with Horizon NJ Health. Please visit our website for information about joining the Horizon NJ Health network.